

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06284

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Linthicum</u>	
c. LENGTH OF STAY IN 1b <u>7 mos.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#417 Shipley Road</u>		d. STREET ADDRESS <u>#417 Shipley Road</u>	
3. NAME OF DECEASED (Type or print) <u>ALBERT CLARENCE ALLEN, SR.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1892</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Master Mariner (Merch. Marine)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Novia Scotia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Howard Burns Allen</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW 11</u>		16. SOCIAL SECURITY NO. <u>686 12 3307A</u>	
17. INFORMANT <u>Mrs. Albert C. Allen, Jr.</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>		24a. REC'D BY REGISTRAR <u>June 29 '59</u>	
ADDRESS <u>Ellen Bunnell, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. K. K. K.</u>	

MEDICAL CERTIFICATION

6290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anarundel</u> <u>Anne Grundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1526-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anarundel. Co. Hospital</u>		d. STREET ADDRESS <u>11411. Rockville. Pike</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maude</u> First <u>Allwine</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11. 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Holsen Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Nancy B. LeFoe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>MO</u>	
17. INFORMANT <u>Louis P. Allwine</u>		Address <u>11411. Rockville. Pike</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>331X</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-7-59</u> to <u>6-7-59</u> , that I last saw the deceased alive on <u>6-7-59</u> , and that death occurred at <u>1:52 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St</u> DATE SIGNED <u>6-7-59</u> ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u> <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.11.1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington. VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-11-81 BY 1043
1043

6331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 10 mo. 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1421 Mosher Street			
3. NAME OF DECEASED (Type or print) First Governor Middle Barnes Last Barnes				4. DATE OF DEATH Month 6 Day 29 Year 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/98		9. AGE (In years last birthday) yrs. 61	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Barnes				14. MOTHER'S MAIDEN NAME Mary Askew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforation of Tuberculous Intestinal DUE TO (c) Pulmonary Tuberculosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 8/24 , 19 51 , to 6/29 , 19 59 , that I last saw the deceased alive on 6/29 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6/29/59							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		M.D. Crownsville State Hospital, Md. 6/29/59					
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md. 6/29/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-59		22c. NAME OF CEMETERY OR CREMATORY Crownsville St. Hosp.		22d. LOCATION (City, town, or county) (State) Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Harris</i>				24. REC'D BY REGISTRAR DATE JUL 8 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
ISM 9/58

6291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle C. Last BENNING		4. DATE OF DEATH Month June Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Foreman		10b. KIND OF BUSINESS OR INDUSTRY City of Annapolis	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Earl C. Benning		14. MOTHER'S MAIDEN NAME Fredericka L. Witt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Informant Mrs. Gerorgetta Benning Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Ventricular Fibrillation DUE TO (b) Coronary Thrombosis DUE TO (c) lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 30 min. 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1956 to 6-24-1959 that I last saw the deceased alive on 6-24-1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw St., DATE SIGNED 6/24/59			
ACTUAL SIGNATURE James R. Martin		M.D. 6 Shaw St.,	
PHYSICIAN'S NAME (Type) James R. Martin		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/26/1959	22c. NAME OF CEMETERY OR CREMATORY St. Anne's	22d. LOCATION (City, town, or county) (State) Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Taylor & Sons		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR JUN 29 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased: *John C. Brown*
Age: *45*
Sex: *Male*
Race: *White*
Date of death: *Jan 15 1900*
Place of death: *Home*

Signature of physician: *[Signature]*
Signature of coroner: *[Signature]*
Signature of registrar: *[Signature]*

Signature of informant: *[Signature]*
Signature of witness: *[Signature]*

Signature of registrar: *[Signature]*
Signature of coroner: *[Signature]*

Signature of informant: *[Signature]*
Signature of witness: *[Signature]*

Signature of registrar: *[Signature]*
Signature of coroner: *[Signature]*

Signature of informant: *[Signature]*
Signature of witness: *[Signature]*

Signature of registrar: *[Signature]*
Signature of coroner: *[Signature]*

Signature of informant: *[Signature]*
Signature of witness: *[Signature]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 12, 13, 14 Film 6244 7-2-59 et

06288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near North Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> <u>69x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rose Haven Motel</u>		d. STREET ADDRESS <u>311 E. 7th Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>BERKOLDS</u> Last <u>BERKOLDS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Latvia</u>	
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>048-24-9242</u>	
17. INFORMANT <u>Leopold Berkolds</u>		Address <u>155 Woodruff Brooklyn, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion.</u> <u>420.1</u> <u>MYOCARDIAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction.</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		DATE SIGNED <u>6/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	
24a. REC'D BY REGISTRAR <u>JUN 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06289

Reg. Dist. No.

6333

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6 MONTH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS St. Inigoes 18x-2	
3. NAME OF DECEASED (Type or print) MARY First EDITH Middle BIRCH Last		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME WILLIAM F. FORD		14. MOTHER'S MAIDEN NAME ALICE PEMBROKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT W. Mace Birch		Address St. Inigoes, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-9 , 19 48 , to 6-17 , 19 59 , that I last saw the deceased alive on 6-12 , 19 59 , and that death occurred at 6:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 45 Franklin St DATE SIGNED ACTUAL SIGNATURE Edith Rodler M.D. M.D. ANNA POLIS M.D. PHYSICIAN'S NAME (Type) EDITH RODLER M.D. ANNA POLIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/59	22c. NAME OF CEMETERY OR CREMATORY St. Michael's	22d. LOCATION (City, town, or county) (State) Ridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR JUN 22 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

633

NAME OF DECEASED Mrs. Anna (Arndt)		SEX Female	
DATE OF BIRTH May 1, 1878		PLACE OF BIRTH Prussia	
DATE OF DEATH May 1, 1933		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 A.M.		CAUSE OF DEATH Senility	
DISEASE OR INJURY Senility		MANNER OF DEATH Natural	
OCCASION OF DEATH None		SIGNATURE OF DECEASED None	
SIGNATURE OF WITNESSES None		SIGNATURE OF PHYSICIAN None	
SIGNATURE OF CLERK None		SIGNATURE OF REGISTRAR None	
SIGNATURE OF JUDGE None		SIGNATURE OF SHERIFF None	
SIGNATURE OF CORONER None		SIGNATURE OF JURY None	
SIGNATURE OF DISTRICT ATTORNEY None		SIGNATURE OF COUNTY CLERK None	
SIGNATURE OF CITY CLERK None		SIGNATURE OF STATE CLERK None	
SIGNATURE OF DEPARTMENT CLERK None		SIGNATURE OF HEALTH COMMISSIONER None	
SIGNATURE OF HEALTH DEPARTMENT None		SIGNATURE OF BALTIMORE CITY None	
SIGNATURE OF BALTIMORE COUNTY None		SIGNATURE OF ANNE ARUNDEL COUNTY None	
SIGNATURE OF CARROLL COUNTY None		SIGNATURE OF CECIL COUNTY None	
SIGNATURE OF FREDERICK COUNTY None		SIGNATURE OF GARRETT COUNTY None	
SIGNATURE OF HARRIS COUNTY None		SIGNATURE OF HOWARD COUNTY None	
SIGNATURE OF MONTGOMERY COUNTY None		SIGNATURE OF PRINCE GEORGES COUNTY None	
SIGNATURE OF ST. MARY'S COUNTY None		SIGNATURE OF TALENT COUNTY None	
SIGNATURE OF WASHINGTON COUNTY None		SIGNATURE OF WEST MARYLAND COUNTY None	
SIGNATURE OF WICOMICO COUNTY None		SIGNATURE OF WYOMING COUNTY None	

6334

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Elm Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Madeline Middle C. Last Birmingham		4. DATE OF DEATH Month June Day 8 Year 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Becks Bakery	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Casey		14. MOTHER'S MAIDEN NAME Ida Applesteel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mr Thomas Birmingham, 108 Elm Ave, Ferndale	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma. 170x DUE TO (b) Ca of Breast 4 yrs. post op Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, jaundice			
18. INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to June 7 , 19 59 , that I last saw the deceased alive on May 30 , 19 59 , and that death occurred at 3:40 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry B. Scott M.D.		ADDRESS (Street, city or town, state) 721 Medical Arts Bldg DATE SIGNED 6/9/59	
PHYSICIAN'S NAME (Type) Harry B. Scott M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.		24a. REC'D BY REGISTRAR JUN 10 '59	
ADDRESS 4101 Edmondson Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. A.

108 Elm Ave

108 Elm Ave

108 Elm Ave

108 Elm Ave

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108 Elm Ave

108 Elm Ave

108 Elm Ave

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108 Elm Ave

6335

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Bell Last Blake			4. DATE OF DEATH Month 6 Day 29 Year 1959				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/87		9. AGE (In years last birthday) yrs. 71		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) -----			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jeffrey Wickman				
14. MOTHER'S MAIDEN NAME Mariah Ross			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia and Uremia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis of Brain Stem DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Generalized Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				
20f. (City or town) -----			(County) (State)				
21. I certify that I attended the deceased from 6/23 , 19 59 , to 6/29 , 19 59 , that I last saw the deceased alive on 6/29 , 19 59 , and that death occurred at 3:40A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6/29/59 ACTUAL SIGNATURE Lionel McHenry Mapp, M. D. PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. 6/29/59							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) (State)		22f. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert Williams		23a. ADDRESS 1701-130 Bond		23b. REC'D BY REGISTRAR DATE JUL 7 '59			
23c. REGISTRAR'S SIGNATURE Arthur S. Huns		23d. REGISTRAR'S SIGNATURE					

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10841

MAINTENANCE OF RECORDS - BUREAU OF

CERTIFICATE OF DEATH

1933

M

1

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

Reg. Dist. No.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

6303

00803

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of birth: Jan 15, 1918

5. Date of death: Dec 10, 1963

6. Place of death: New York City, N.Y.

7. Cause of death: Heart disease

8. Signature of physician: Dr. J. Smith

9. Signature of registrar: John Doe

10. Date of registration: Dec 15, 1963

6336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>312 Church ST.</u>		d. STREET ADDRESS <u>312 Church ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Brokos</u> Last <u>Brokos</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-1309</u>	
17. INFORMANT <u>Leonard Brokos</u> Address <u>312 Church ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>cardiac decompensation</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>6-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>59</u> , and that death occurred at <u>2 P</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schmitzer</u> M.D.		ADDRESS (Street, city or town, state) <u>3904 S. Vanover St.</u> DATE SIGNED <u>6-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Eugene Schmitzer, M.D.</u>		<u>Balto. 25, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Hill</u>		ADDRESS <u>1501 E. Fort Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

6830

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1923</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. DATE OF DEATH <i>Jan 20 1968</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF NEXT OF KIN <i>John Doe</i>	
17. SIGNATURE OF BURIAL OFFICIAL <i>John Doe</i>		18. SIGNATURE OF CHURCH OFFICIAL <i>John Doe</i>	
19. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		20. SIGNATURE OF CEMETERY <i>John Doe</i>	
21. SIGNATURE OF MARRIAGE OFFICIAL <i>John Doe</i>		22. SIGNATURE OF DIVORCE OFFICIAL <i>John Doe</i>	
23. SIGNATURE OF PROBATE OFFICIAL <i>John Doe</i>		24. SIGNATURE OF ESTATE OFFICIAL <i>John Doe</i>	
25. SIGNATURE OF SOCIAL SECURITY OFFICIAL <i>John Doe</i>		26. SIGNATURE OF MEDICAL OFFICIAL <i>John Doe</i>	
27. SIGNATURE OF NURSING HOME OFFICIAL <i>John Doe</i>		28. SIGNATURE OF HOSPITAL OFFICIAL <i>John Doe</i>	
29. SIGNATURE OF CORONER OFFICIAL <i>John Doe</i>		30. SIGNATURE OF JURY OFFICIAL <i>John Doe</i>	
31. SIGNATURE OF JUDGE OFFICIAL <i>John Doe</i>		32. SIGNATURE OF CLERK OFFICIAL <i>John Doe</i>	
33. SIGNATURE OF SHERIFF OFFICIAL <i>John Doe</i>		34. SIGNATURE OF DEPUTY SHERIFF OFFICIAL <i>John Doe</i>	
35. SIGNATURE OF TOWNSHIP OFFICIAL <i>John Doe</i>		36. SIGNATURE OF COUNTY OFFICIAL <i>John Doe</i>	
37. SIGNATURE OF STATE OFFICIAL <i>John Doe</i>		38. SIGNATURE OF FEDERAL OFFICIAL <i>John Doe</i>	
39. SIGNATURE OF INTERNATIONAL OFFICIAL <i>John Doe</i>		40. SIGNATURE OF OTHER OFFICIAL <i>John Doe</i>	

6337

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20yr11mo21days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		1617-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						d. STREET ADDRESS 105 Tulip Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Sally Brooks						4. DATE OF DEATH Month Day Year 6 18 1959					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890		9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Campbell						14. MOTHER'S MAIDEN NAME Nancy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and Dehydration 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Gangrene of both legs DUE TO (c) Generalized Arteriosclerosis Associated with Senile Psychosis										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that I attended the deceased from 7/27 , 19 38 , to 6/18 , 19 59 , that I last saw the deceased alive on 6/18 , 19 59 , and that death occurred at 12:18 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6/18/59											
ACTUAL SIGNATURE <i>L. Benedict</i>				M.D. Crownsville State Hospital, Md. 6/18/59							
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				Crownsville State Hospital, Md. 6/18/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/22/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn			22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Stewart</i>						ADDRESS 30 X at H.B.		24a. REC'D BY REGISTRAR JUN 22 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur E. K...</i>	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10301

CERTIFICATE OF DEATH

1950

1

MADE IN

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF WITNESS
DATE OF REGISTRATION

6338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2mo. 5days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		1556-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 103 Ritchie Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Nathaniel		Middle John		Last Carter	
4. DATE OF DEATH		Month 6		Day 30		Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/39		9. AGE (In years last birthday) 20	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John S. Carter				14. MOTHER'S MAIDEN NAME Mary Lancaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure, Acute 300.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Schizophrenia, Catatonic Type DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/25 , 19 59 , to 6/30 , 19 59 , that I last saw the deceased alive on 6/30 , 19 59 , and that death occurred at 6:15A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 6/30/59 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 6/30/59							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/30/59		22c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery MD	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS [Address]		24a. REC'D BY REGISTRAR DATE JUL 6		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Form No. 1

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Place of Birth	
Manner of Death		Time of Death		Physician's Signature	
Burial Place		Burial Date		Burial Time	
Funeral Home		Funeral Date		Funeral Time	
Interment Place		Interment Date		Interment Time	
Witnesses		Registrar's Signature		Registrar's Office	
Date of Filing		Filing Office		Filing Number	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6339

Item 2 Filed 7-7-59 at

CERTIFICATE OF DEATH

06296

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A. A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE		c. LENGTH OF STAY IN 1b 3 yrs 8 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SANNS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE W. CECIL		4. DATE OF DEATH JUNE 26 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1875 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME REV. CHARLES A. JOYCE		14. MOTHER'S MAIDEN NAME MARY HANK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mary Newberger - Millersville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular Disease DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4-58 to June 25-59 , that I last saw the deceased alive on 6-19-59 , and that death occurred at 8:40 AM from the causes and on the date stated above.		ADDRESS (Street, or town, or county) DATE SIGNED	
ACTUAL SIGNATURE DR. JOSEPH LITSEY M.D.		Physician's NAME (Type) ODENTON, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 28-59	22c. NAME OF CEMETERY OR CREMATORY Cross Roads Cemetery	22d. LOCATION (City, town, or county) (State) Millersville Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Gayler Sons		ADDRESS Annapolis Md	
24a. REC'D BY REGISTRAR JUL 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH INVESTIGATOR	
NAME OF DECEASED MILLENBERRY, CECIL R.		NAME OF DECEASED MILLENBERRY, CECIL R.	
AGE 40		AGE 40	
SEX MALE		SEX MALE	
DATE OF DEATH JUNE 10, 1915		DATE OF DEATH JUNE 10, 1915	
PLACE OF DEATH HOME		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF DEATH INVESTIGATOR	
OFFICIAL SEAL		OFFICIAL SEAL	

6340
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
c. LENGTH OF STAY IN 1b 8 mos.		d. STREET ADDRESS Box 83A, Rte. 2, Colonial Beach Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Box 83A, Rte. 2, Colonial Beach Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES IRVIN CHANEY		4. DATE OF DEATH Month JUNE Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County Employee		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles R. Chaney		14. MOTHER'S MAIDEN NAME Mary Elizabeth Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Box 949, Rte 2. Miss Matilda Cook, Pasadena, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 YEAR 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 9 , 1958, to MAY 22 , 1959, that I last saw the deceased alive on MAY 22 , 1959, and that death occurred at 11:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) MOUNTAIN RD. DATE SIGNED 6-2-59 ACTUAL SIGNATURE Arthur Lankford Jr. M.D. PASADENA, MD. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/59	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Howard County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR JUN 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Lankford			

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06298

6341

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundle</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.Ct.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8453 Bay Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>L.</u> Last <u>Clatchey</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1891</u>	9. AGE (In years last birthday) <u>67 yrs</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
13. FATHER'S NAME <u>Samuel Newton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Scherer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-20-1480</u>		17. INFORMANT <u>Ruth Clatchey wife 8453 Bay Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June 2, 1958</u> to <u>August 28, 1959</u> , that I last saw the deceased alive on <u>8-8-1958</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Otto Vogel M.D.</u>				ADDRESS (Street, city or town, state) <u>403 Ritchie Highway</u>			
PHYSICIAN'S NAME (Type) <u>Otto Vogel, M.D.</u>				DATE SIGNED <u>6-7-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 11, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Old Frederick Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>KRAUSE FUNERAL HOME 1216 S. Charles St.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Blank]		SEX [Blank]		AGE [Blank]		DATE OF BIRTH [Blank]		PLACE OF BIRTH [Blank]		PLACE OF DEATH [Blank]	
OCCUPATION [Blank]		CAUSE OF DEATH [Blank]		MANNER OF DEATH [Blank]		TIME OF DEATH [Blank]		DATE OF DEATH [Blank]		PLACE OF DEATH [Blank]	
SIGNATURE OF PHYSICIAN [Blank]		SIGNATURE OF CORONER [Blank]		SIGNATURE OF JURY [Blank]		SIGNATURE OF WITNESSES [Blank]		SIGNATURE OF DECEASED [Blank]		SIGNATURE OF SURVIVORS [Blank]	
NAME OF PHYSICIAN [Blank]		NAME OF CORONER [Blank]		NAME OF JURY [Blank]		NAME OF WITNESSES [Blank]		NAME OF DECEASED [Blank]		NAME OF SURVIVORS [Blank]	
ADDRESS OF PHYSICIAN [Blank]		ADDRESS OF CORONER [Blank]		ADDRESS OF JURY [Blank]		ADDRESS OF WITNESSES [Blank]		ADDRESS OF DECEASED [Blank]		ADDRESS OF SURVIVORS [Blank]	
CITY OF PHYSICIAN [Blank]		CITY OF CORONER [Blank]		CITY OF JURY [Blank]		CITY OF WITNESSES [Blank]		CITY OF DECEASED [Blank]		CITY OF SURVIVORS [Blank]	
STATE OF PHYSICIAN [Blank]		STATE OF CORONER [Blank]		STATE OF JURY [Blank]		STATE OF WITNESSES [Blank]		STATE OF DECEASED [Blank]		STATE OF SURVIVORS [Blank]	
COUNTY OF PHYSICIAN [Blank]		COUNTY OF CORONER [Blank]		COUNTY OF JURY [Blank]		COUNTY OF WITNESSES [Blank]		COUNTY OF DECEASED [Blank]		COUNTY OF SURVIVORS [Blank]	
DISTRICT OF PHYSICIAN [Blank]		DISTRICT OF CORONER [Blank]		DISTRICT OF JURY [Blank]		DISTRICT OF WITNESSES [Blank]		DISTRICT OF DECEASED [Blank]		DISTRICT OF SURVIVORS [Blank]	
PARISH OF PHYSICIAN [Blank]		PARISH OF CORONER [Blank]		PARISH OF JURY [Blank]		PARISH OF WITNESSES [Blank]		PARISH OF DECEASED [Blank]		PARISH OF SURVIVORS [Blank]	
TOWNSHIP OF PHYSICIAN [Blank]		TOWNSHIP OF CORONER [Blank]		TOWNSHIP OF JURY [Blank]		TOWNSHIP OF WITNESSES [Blank]		TOWNSHIP OF DECEASED [Blank]		TOWNSHIP OF SURVIVORS [Blank]	
WARD OF PHYSICIAN [Blank]		WARD OF CORONER [Blank]		WARD OF JURY [Blank]		WARD OF WITNESSES [Blank]		WARD OF DECEASED [Blank]		WARD OF SURVIVORS [Blank]	
BLOCK OF PHYSICIAN [Blank]		BLOCK OF CORONER [Blank]		BLOCK OF JURY [Blank]		BLOCK OF WITNESSES [Blank]		BLOCK OF DECEASED [Blank]		BLOCK OF SURVIVORS [Blank]	
LOT OF PHYSICIAN [Blank]		LOT OF CORONER [Blank]		LOT OF JURY [Blank]		LOT OF WITNESSES [Blank]		LOT OF DECEASED [Blank]		LOT OF SURVIVORS [Blank]	
SECTION OF PHYSICIAN [Blank]		SECTION OF CORONER [Blank]		SECTION OF JURY [Blank]		SECTION OF WITNESSES [Blank]		SECTION OF DECEASED [Blank]		SECTION OF SURVIVORS [Blank]	
QUARTER OF PHYSICIAN [Blank]		QUARTER OF CORONER [Blank]		QUARTER OF JURY [Blank]		QUARTER OF WITNESSES [Blank]		QUARTER OF DECEASED [Blank]		QUARTER OF SURVIVORS [Blank]	
HALF OF PHYSICIAN [Blank]		HALF OF CORONER [Blank]		HALF OF JURY [Blank]		HALF OF WITNESSES [Blank]		HALF OF DECEASED [Blank]		HALF OF SURVIVORS [Blank]	
PART OF PHYSICIAN [Blank]		PART OF CORONER [Blank]		PART OF JURY [Blank]		PART OF WITNESSES [Blank]		PART OF DECEASED [Blank]		PART OF SURVIVORS [Blank]	
OTHER OF PHYSICIAN [Blank]		OTHER OF CORONER [Blank]		OTHER OF JURY [Blank]		OTHER OF WITNESSES [Blank]		OTHER OF DECEASED [Blank]		OTHER OF SURVIVORS [Blank]	
NAME OF PHYSICIAN [Blank]		NAME OF CORONER [Blank]		NAME OF JURY [Blank]		NAME OF WITNESSES [Blank]		NAME OF DECEASED [Blank]		NAME OF SURVIVORS [Blank]	
ADDRESS OF PHYSICIAN [Blank]		ADDRESS OF CORONER [Blank]		ADDRESS OF JURY [Blank]		ADDRESS OF WITNESSES [Blank]		ADDRESS OF DECEASED [Blank]		ADDRESS OF SURVIVORS [Blank]	
CITY OF PHYSICIAN [Blank]		CITY OF CORONER [Blank]		CITY OF JURY [Blank]		CITY OF WITNESSES [Blank]		CITY OF DECEASED [Blank]		CITY OF SURVIVORS [Blank]	
STATE OF PHYSICIAN [Blank]		STATE OF CORONER [Blank]		STATE OF JURY [Blank]		STATE OF WITNESSES [Blank]		STATE OF DECEASED [Blank]		STATE OF SURVIVORS [Blank]	
COUNTY OF PHYSICIAN [Blank]		COUNTY OF CORONER [Blank]		COUNTY OF JURY [Blank]		COUNTY OF WITNESSES [Blank]		COUNTY OF DECEASED [Blank]		COUNTY OF SURVIVORS [Blank]	
DISTRICT OF PHYSICIAN [Blank]		DISTRICT OF CORONER [Blank]		DISTRICT OF JURY [Blank]		DISTRICT OF WITNESSES [Blank]		DISTRICT OF DECEASED [Blank]		DISTRICT OF SURVIVORS [Blank]	
PARISH OF PHYSICIAN [Blank]		PARISH OF CORONER [Blank]		PARISH OF JURY [Blank]		PARISH OF WITNESSES [Blank]		PARISH OF DECEASED [Blank]		PARISH OF SURVIVORS [Blank]	
TOWNSHIP OF PHYSICIAN [Blank]		TOWNSHIP OF CORONER [Blank]		TOWNSHIP OF JURY [Blank]		TOWNSHIP OF WITNESSES [Blank]		TOWNSHIP OF DECEASED [Blank]		TOWNSHIP OF SURVIVORS [Blank]	
WARD OF PHYSICIAN [Blank]		WARD OF CORONER [Blank]		WARD OF JURY [Blank]		WARD OF WITNESSES [Blank]		WARD OF DECEASED [Blank]		WARD OF SURVIVORS [Blank]	
BLOCK OF PHYSICIAN [Blank]		BLOCK OF CORONER [Blank]		BLOCK OF JURY [Blank]		BLOCK OF WITNESSES [Blank]		BLOCK OF DECEASED [Blank]		BLOCK OF SURVIVORS [Blank]	
LOT OF PHYSICIAN [Blank]		LOT OF CORONER [Blank]		LOT OF JURY [Blank]		LOT OF WITNESSES [Blank]		LOT OF DECEASED [Blank]		LOT OF SURVIVORS [Blank]	
SECTION OF PHYSICIAN [Blank]		SECTION OF CORONER [Blank]		SECTION OF JURY [Blank]		SECTION OF WITNESSES [Blank]		SECTION OF DECEASED [Blank]		SECTION OF SURVIVORS [Blank]	
QUARTER OF PHYSICIAN [Blank]		QUARTER OF CORONER [Blank]		QUARTER OF JURY [Blank]		QUARTER OF WITNESSES [Blank]		QUARTER OF DECEASED [Blank]		QUARTER OF SURVIVORS [Blank]	
HALF OF PHYSICIAN [Blank]		HALF OF CORONER [Blank]		HALF OF JURY [Blank]		HALF OF WITNESSES [Blank]		HALF OF DECEASED [Blank]		HALF OF SURVIVORS [Blank]	
PART OF PHYSICIAN [Blank]		PART OF CORONER [Blank]		PART OF JURY [Blank]		PART OF WITNESSES [Blank]		PART OF DECEASED [Blank]		PART OF SURVIVORS [Blank]	
OTHER OF PHYSICIAN [Blank]		OTHER OF CORONER [Blank]		OTHER OF JURY [Blank]		OTHER OF WITNESSES [Blank]		OTHER OF DECEASED [Blank]		OTHER OF SURVIVORS [Blank]	



This is a duplicate of the original certificate of death filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the _____ day of _____, 19____, at _____, Maryland, in the _____ District, _____ County, _____ State of Maryland, and is not to be used for any purpose other than for the purpose for which it was issued.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06299	
Item 18 Film 245 7-20-59 ams										6293	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 102 Clay Street					d. STREET ADDRESS 102 Clay Street						
3. NAME OF DECEASED (Type or print) First ROBERT Middle COLEMAN Last COLEMAN					4. DATE OF DEATH Month June Day 9 Year 19 59						
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-1959		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Coleman					14. MOTHER'S MAIDEN NAME Maxine Tongue						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Maxine Tongue 102 Clay St.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Charles S. Petty			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Charles S. Petty, M.D.			DATE SIGNED 6/10/59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-12-59			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill			22d. LOCATION (City, town, or county) (State) Annapolis Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese #108 Wash St. Annapolis					ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

9VVVVVVVVVV

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton Ft. Meade		c. LENGTH OF STAY IN 1b Few seconds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 16 25-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Meade Hospital				d. STREET ADDRESS 6715 Ingraham St. East Pine		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Paul Conrad				4. DATE OF DEATH Month June Day 9th. Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/23		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed at The U.S. National Security				10b. KIND OF BUSINESS OR INDUSTRY Akron, Ohio.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard J. Conrad				14. MOTHER'S MAIDEN NAME Nora C. Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 11 World War		16. SOCIAL SECURITY NO. 579-22-5410		17. INFORMANT Address Bernard J. Conrad (father)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home</i>				ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DATE JUN 12 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6343

CERTIFICATE OF DEATH

06301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glennburne md</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Home</u>		d. STREET ADDRESS <u>1013 n. Carlton st</u>	
3. NAME OF DECEASED (Type or print) <u>John Craig</u> First Middle Last		4. DATE OF DEATH <u>June 30 1959</u> 19 <u>19</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Judy Johnson</u> Address <u>1013 n. Carlton st</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis obliterans</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>? yrs.</u> <u>? yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Elephantiasis of both legs due to venous thrombosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 11, 1959</u> , to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 20, 1959</u> , 19 <u>19</u> and that death occurred at <u>10:10P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Pair</u> M.D. <u>400 N. Carrollton Avenue</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>		<u>Baltimore 23, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>7-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt auburn</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. S. Kelson</u> ADDRESS <u>1348 n. calhoun st</u>		24a. REC'D BY REGISTRAR <u>Jul 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6344

CERTIFICATE OF DEATH

06302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAR HARBOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bar Harbor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JOHNSON ROAD</u>		d. STREET ADDRESS <u>Johnson Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORA MAY DANNER</u>		4. DATE OF DEATH Month Day Year <u>JUNE 16 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EDNA GREENHOLTZ</u>		Address <u>BAR HARBOR, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>20 YEARS</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 10, 1959</u> , to <u>JUNE 16, 1959</u> , that I last saw the deceased alive on <u>JUNE 10, 1959</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8471 FT. SMALLWOOD ROAD PASADENA, MD</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reformed</u>	22d. LOCATION (City, town, or county) (State) <u>Knoxville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Felt</u>		ADDRESS <u>Brunswick, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06303

6294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>			d. STREET ADDRESS <u>Box 388, Route # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Covode</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 September 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Maryland</u>	
13. FATHER'S NAME <u>Charles D. DAVIS</u>			14. MOTHER'S MAIDEN NAME <u>Sarah H. COVODE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>36</u> years		16. SOCIAL SECURITY NO.		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Abdominal Aorta</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Aneurysm</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis Terminal</u>					
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 April</u> , 1959, to <u>23 June</u> , 1959, that I last saw the deceased alive on <u>23 June</u> , 1959, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Richard I. Hochman</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Richard I. HOCHMAN LT MC USNR</u> <u>U.S. Naval Hospital, Annapolis, Md. 6-23-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

Item 18 Film 246 7-5-59
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups c. LENGTH OF STAY IN 1b 1 1/2 Month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Annapolis Rd.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Patricia Anne Davis First Middle Last			4. DATE OF DEATH June 28th. 19 59 Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/59	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR 2 Months 9 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Ernest Thalbert Davis			14. MOTHER'S MAIDEN NAME Marguerite Perkins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Marguerite Davis (mother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 29, 1959	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	
				22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley			24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		
ADDRESS Hopping and Kirkley, Glen Burnie, Md.			DATE JUL 2 '59		

12033244XW5 (over)

add Infd. code
to card 6 cause

0/5/10
10/5/10
10/5/10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06306

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Whiteford Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roy Hammer Dickenson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/97</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>I</u>		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. A. Dickenson</u>				14. MOTHER'S MAIDEN NAME <u>H. Texie Hammer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>World I & II</u>				16. SOCIAL SECURITY NO. <u>217-05-9260</u>		17. INFORMANT <u>Papers found on deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of the head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6/11</u> p. m. <u>19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pasadena Anne Arundel Md.</u>	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/12/59</u>		22b. DATE THEREOF <u>6/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HAMMER FAMILY CEM</u>		22d. LOCATION (City, town, or county) (State) <u>FRANKLIN W. VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm G. Tucker & Sons</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6347 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 year	
d. 107 OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Alview Rd. Country Club Estate		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) David Joseph Doyle		4. DATE OF DEATH June 30th. 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/50
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Frankfurt, Germany,		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Foster father: Warren Grantville Doyle		14. MOTHER'S MAIDEN NAME Foster mother: Viva Parla	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Warren Grantville Doyle (foster father)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution, while playing with T.V. DUE TO 9140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was playing with T.V. and Antenna.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 4 6/30/59 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Glen Burnie, A.A. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 7/3/59	
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKLEY		ADDRESS Glen Burnie, Md.	
24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

STATE
HEALTH

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

NAME

DATE

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

PREVIOUS MARRIAGES

REASON FOR DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

Signature of Registrar

Signature of Examiner

Signature of Interviewer

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6348 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 1 year		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Alview Rd. Country Club Estate.		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) Michael Edward Doyle		4. DATE OF DEATH June 30th. 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/52
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Frankfurt, Germany.	
11. BIRTHPLACE (State or foreign country) Naturalized USA		12. CITIZEN OF WHAT COUNTRY Naturalized USA	
13. FATHER'S NAME Foster parents: Warren Grantville Doyle		14. MOTHER'S MAIDEN NAME Viva Parla	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Warren G. Doyle (foster father)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution, while playing with T.V. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 914.0 Was playing with the back part of T.V. and with antenna.			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was playing with the back part of T.V. and with antenna.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 6/30/59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Glen Burnie, A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 7/3/59	
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Tirmoney		ADDRESS Glen Burnie	
24a. REC'D BY REGISTRAR JUL 6 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06309

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

Item 20 Film 245 7-22-59

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>6295</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> b. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6319 Belcor Street</u> <u>3V01-4</u>		d. STREET ADDRESS <u>Baltimore, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S.O.A. Anne Arundel General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>L. Ewing</u> Middle <u>Lost</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>1953</u> <u>12/23/53</u> <u>5</u> yrs.		9. AGE (In years last birthday) <u>5</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>LAWTON E. EWING</u>				14. MOTHER'S MAIDEN NAME <u>DELDRIS SIMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>L. E. EWING - FATHER - SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Submer</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>While swimming</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6/27/59</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severna Park</u> <u>Magothy River</u>		20f. (City or town) (County) (State) <u>Riverdale</u> <u>A.A.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Lohrhardt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Lohrhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODNON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bailey, Hurdock, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G244 7-7-59 et

CERTIFICATE OF DEATH

6349

06310

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Md. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 6 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO 16X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fort Meade Rd. Private home				d. STREET ADDRESS Route I		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTIE MAY FERGUSON				4. DATE OF DEATH JUNE 19 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 August 1889	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME James FOWLER				14. MOTHER'S MAIDEN NAME Fannie Brady			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Fort Meade Road		17. INFORMANT SEVERN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						1 mo.	
332x DUE TO Cerebral Arteriosclerosis						app 6 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis							
DUE TO (c) Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Auricular Fibrillation, slow, chronic; Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 16, 1959 to June 19, 1959 , that I last saw the deceased alive on June 16, 1959 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jose M. Yosunico M.D.				ADDRESS (Street, city or town, state) RFD #1 Jessup, Md. DATE SIGNED 6-19-59			
PHYSICIAN'S NAME (Type) Jose M. Yosunico, M. D.				R F D. 1 Jessup, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/59		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. ADDRESS Upper Marlboro, Md.				24a. REC'D BY REGISTRAR JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED JAMES T. JONES		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 1945		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. DATE OF BIRTH 1900		8. PLACE OF BIRTH Maryland		9. OCCUPATION Farmer	
10. MARITAL STATUS Married		11. EDUCATION High School		12. RELIGION Methodist	
13. PRESENT ADDRESS 123 Main St, Baltimore, Md.		14. DATE OF DEATH 1945		15. PLACE OF DEATH Home	
16. CAUSE OF DEATH Heart Disease		17. DATE OF DEATH 1945		18. PLACE OF DEATH Home	
19. PRESENT ADDRESS 123 Main St, Baltimore, Md.		20. DATE OF DEATH 1945		21. PLACE OF DEATH Home	
22. CAUSE OF DEATH Heart Disease		23. DATE OF DEATH 1945		24. PLACE OF DEATH Home	
25. PRESENT ADDRESS 123 Main St, Baltimore, Md.		26. DATE OF DEATH 1945		27. PLACE OF DEATH Home	
28. CAUSE OF DEATH Heart Disease		29. DATE OF DEATH 1945		30. PLACE OF DEATH Home	
31. PRESENT ADDRESS 123 Main St, Baltimore, Md.		32. DATE OF DEATH 1945		33. PLACE OF DEATH Home	
34. CAUSE OF DEATH Heart Disease		35. DATE OF DEATH 1945		36. PLACE OF DEATH Home	
37. PRESENT ADDRESS 123 Main St, Baltimore, Md.		38. DATE OF DEATH 1945		39. PLACE OF DEATH Home	
40. CAUSE OF DEATH Heart Disease		41. DATE OF DEATH 1945		42. PLACE OF DEATH Home	
43. PRESENT ADDRESS 123 Main St, Baltimore, Md.		44. DATE OF DEATH 1945		45. PLACE OF DEATH Home	
46. CAUSE OF DEATH Heart Disease		47. DATE OF DEATH 1945		48. PLACE OF DEATH Home	
49. PRESENT ADDRESS 123 Main St, Baltimore, Md.		50. DATE OF DEATH 1945		51. PLACE OF DEATH Home	
52. CAUSE OF DEATH Heart Disease		53. DATE OF DEATH 1945		54. PLACE OF DEATH Home	
55. PRESENT ADDRESS 123 Main St, Baltimore, Md.		56. DATE OF DEATH 1945		57. PLACE OF DEATH Home	
58. CAUSE OF DEATH Heart Disease		59. DATE OF DEATH 1945		60. PLACE OF DEATH Home	
61. PRESENT ADDRESS 123 Main St, Baltimore, Md.		62. DATE OF DEATH 1945		63. PLACE OF DEATH Home	
64. CAUSE OF DEATH Heart Disease		65. DATE OF DEATH 1945		66. PLACE OF DEATH Home	
67. PRESENT ADDRESS 123 Main St, Baltimore, Md.		68. DATE OF DEATH 1945		69. PLACE OF DEATH Home	
70. CAUSE OF DEATH Heart Disease		71. DATE OF DEATH 1945		72. PLACE OF DEATH Home	
73. PRESENT ADDRESS 123 Main St, Baltimore, Md.		74. DATE OF DEATH 1945		75. PLACE OF DEATH Home	
76. CAUSE OF DEATH Heart Disease		77. DATE OF DEATH 1945		78. PLACE OF DEATH Home	
79. PRESENT ADDRESS 123 Main St, Baltimore, Md.		80. DATE OF DEATH 1945		81. PLACE OF DEATH Home	
82. CAUSE OF DEATH Heart Disease		83. DATE OF DEATH 1945		84. PLACE OF DEATH Home	
85. PRESENT ADDRESS 123 Main St, Baltimore, Md.		86. DATE OF DEATH 1945		87. PLACE OF DEATH Home	
88. CAUSE OF DEATH Heart Disease		89. DATE OF DEATH 1945		90. PLACE OF DEATH Home	
91. PRESENT ADDRESS 123 Main St, Baltimore, Md.		92. DATE OF DEATH 1945		93. PLACE OF DEATH Home	
94. CAUSE OF DEATH Heart Disease		95. DATE OF DEATH 1945		96. PLACE OF DEATH Home	
97. PRESENT ADDRESS 123 Main St, Baltimore, Md.		98. DATE OF DEATH 1945		99. PLACE OF DEATH Home	
100. CAUSE OF DEATH Heart Disease		101. DATE OF DEATH 1945		102. PLACE OF DEATH Home	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6350 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06311

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> Va. b. COUNTY <u>Arlington</u> Va.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington, Va.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>712 20th St. Arlington, Va.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ORVAL</u> Middle <u>FOLAND</u> Last <u>FOLAND</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sub. Station Maint.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pepco</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Foland</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Thornberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>World War 1</u>		17. INFORMANT <u>Ethel B. Foland</u> Address <u>712 20th Street, South Arlington, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

NOT RECORDED

U.S. GOVERNMENT PRINTING OFFICE: 1965

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TRAIN OF THOUGHT

ST. LOUIS, MO. 64117

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6351
CERTIFICATE OF DEATH

06312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Shadyside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SALLIE</u> First <u>MARY</u> Middle <u>FORD</u> Last		4. DATE OF DEATH <u>June</u> Month <u>26</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12</u>
9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>JOHN BULL</u>		14. MOTHER'S MAIDEN NAME <u>MARY TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hilda Atwell Shadyside MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>576X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 23, 1959</u> , to <u>June 26, 1959</u> , that I last saw the deceased alive on <u>June 26, 1959</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shadyside, Md.</u> DATE SIGNED <u>6/27/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHNS</u>	22d. LOCATION (City, town, or county) (State) <u>Shadyside, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Buried Harding & Galloway Lead</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Page One of Two

1. PLACE OF DEATH		2. MARRIAGE	
3. SEX		4. RACE	
5. AGE		6. DATE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF BIRTH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER	
17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF NOTARY		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS	
23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CORONER	
25. SIGNATURE OF JUDGE		26. SIGNATURE OF CLERK	
27. SIGNATURE OF NOTARY		28. SIGNATURE OF REGISTRAR	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF PHYSICIAN		32. SIGNATURE OF CORONER	
33. SIGNATURE OF JUDGE		34. SIGNATURE OF CLERK	
35. SIGNATURE OF NOTARY		36. SIGNATURE OF REGISTRAR	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS	
39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF CORONER	
41. SIGNATURE OF JUDGE		42. SIGNATURE OF CLERK	
43. SIGNATURE OF NOTARY		44. SIGNATURE OF REGISTRAR	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF WITNESS	
47. SIGNATURE OF PHYSICIAN		48. SIGNATURE OF CORONER	
49. SIGNATURE OF JUDGE		50. SIGNATURE OF CLERK	
51. SIGNATURE OF NOTARY		52. SIGNATURE OF REGISTRAR	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF PHYSICIAN		56. SIGNATURE OF CORONER	
57. SIGNATURE OF JUDGE		58. SIGNATURE OF CLERK	
59. SIGNATURE OF NOTARY		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS	
63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CORONER	
65. SIGNATURE OF JUDGE		66. SIGNATURE OF CLERK	
67. SIGNATURE OF NOTARY		68. SIGNATURE OF REGISTRAR	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF PHYSICIAN		72. SIGNATURE OF CORONER	
73. SIGNATURE OF JUDGE		74. SIGNATURE OF CLERK	
75. SIGNATURE OF NOTARY		76. SIGNATURE OF REGISTRAR	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF CORONER	
81. SIGNATURE OF JUDGE		82. SIGNATURE OF CLERK	
83. SIGNATURE OF NOTARY		84. SIGNATURE OF REGISTRAR	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESS	
87. SIGNATURE OF PHYSICIAN		88. SIGNATURE OF CORONER	
89. SIGNATURE OF JUDGE		90. SIGNATURE OF CLERK	
91. SIGNATURE OF NOTARY		92. SIGNATURE OF REGISTRAR	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS	
95. SIGNATURE OF PHYSICIAN		96. SIGNATURE OF CORONER	
97. SIGNATURE OF JUDGE		98. SIGNATURE OF CLERK	
99. SIGNATURE OF NOTARY		100. SIGNATURE OF REGISTRAR	

6296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Rt. 9, Box 273</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>R.</u> Last <u>Frank</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	9. AGE (In years last birthday) <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN F. RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. COLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. WILLIAM A. FRANK</u>		Address <u>Rt. 9 - Box 273 PASADENA, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 JUNE, 1959</u> , to <u>6 JUNE, 1959</u> , that I last saw the deceased alive on <u>5 JUNE, 1959</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Berk</u> M.D.		ADDRESS (Street, city or town, state) <u>46 Southgate Ave</u> DATE SIGNED <u>6/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Flanagan Schwal</u>		ADDRESS <u>3512 Frederick Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
6352 CERTIFICATE OF DEATH 06314											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY in 1b 10 yrs. 9mo. 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					d. STREET ADDRESS ?						
3. NAME OF DECEASED (Type or print) First Helen Middle Lena Last Gainor					4. DATE OF DEATH Month 6 Day 30 Year 19 59						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/22/15		9. AGE (In years last birthday) 44 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles Pryor					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat Exhaustion 788.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Dehydration DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Catatonic Schizophrenia, Hepatic Cirrhosis										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 9/7 , 19 48 , to 6/30 , 19 59 , that I last saw the deceased alive on 6/30 , 19 59 , and that death occurred at 3:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 7/1/59 ACTUAL SIGNATURE Lionel McHenry Mapp, M. D. M.D. Crownsville State Hospital, Md. 7/1/59 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 7-5-59		22c. NAME OF CEMETERY OR CREMATORY Papah			22d. LOCATION (City, town, or county) (State) Charles County Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Johnson				ADDRESS 4804 Ca Green		24a. RECEIVED BY REGISTRAR JUL 6 1959		24b. REGISTRAR'S SIGNATURE Robert A. Mapp			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G243 6-12-59 et

Reg. Dist. No.

06315

1. PLACE OF DEATH a. COUNTY <u>HACO</u> 6297 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>52 W Washington St.</u>	
3. NAME OF DECEASED (Type or print) <u>IRENE E GALLOWAY</u>		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1934</u>
9. AGE (In years last birthday) <u>25</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Williams</u>		14. MOTHER'S MARRIED NAME <u>Chene Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Isabella St. Galloway</u>		Address <u>Annapolis Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND OF CHEST</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Paul F. Guerin</u>		DATE SIGNED <u>6-7-59</u>	
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chews Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keese</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraw</u>	
ADDRESS <u>#108 Wash St. Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	
DATE <u>6/9/59</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME(5)
SM 9/55

STATE OF NEW YORK DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of Death: <u>10/15/1968</u></p>	
<p>5. Place of Death: <u>Home</u></p>		<p>6. Address: <u>123 Main St., New York, N.Y. 10001</u></p>	
<p>7. Cause of Death: <u>Myocardial Infarction</u></p>		<p>8. Manner of Death: <u>Natural</u></p>	
<p>9. Signature of Medical Examiner: <u>[Signature]</u></p>		<p>10. Signature of Coroner: <u>[Signature]</u></p>	
<p>11. Date of Examination: <u>10/15/1968</u></p>		<p>12. Time of Examination: <u>10:00 AM</u></p>	
<p>13. Name of Hospital: <u>St. Mary's Hospital</u></p>		<p>14. Name of Physician: <u>Dr. J. Doe</u></p>	
<p>15. Name of Nurse: <u>[Name]</u></p>		<p>16. Name of Assistant: <u>[Name]</u></p>	
<p>17. Name of Witness: <u>[Name]</u></p>		<p>18. Name of Witness: <u>[Name]</u></p>	
<p>19. Name of Witness: <u>[Name]</u></p>		<p>20. Name of Witness: <u>[Name]</u></p>	
<p>21. Name of Witness: <u>[Name]</u></p>		<p>22. Name of Witness: <u>[Name]</u></p>	
<p>23. Name of Witness: <u>[Name]</u></p>		<p>24. Name of Witness: <u>[Name]</u></p>	
<p>25. Name of Witness: <u>[Name]</u></p>		<p>26. Name of Witness: <u>[Name]</u></p>	
<p>27. Name of Witness: <u>[Name]</u></p>		<p>28. Name of Witness: <u>[Name]</u></p>	
<p>29. Name of Witness: <u>[Name]</u></p>		<p>30. Name of Witness: <u>[Name]</u></p>	
<p>31. Name of Witness: <u>[Name]</u></p>		<p>32. Name of Witness: <u>[Name]</u></p>	
<p>33. Name of Witness: <u>[Name]</u></p>		<p>34. Name of Witness: <u>[Name]</u></p>	
<p>35. Name of Witness: <u>[Name]</u></p>		<p>36. Name of Witness: <u>[Name]</u></p>	
<p>37. Name of Witness: <u>[Name]</u></p>		<p>38. Name of Witness: <u>[Name]</u></p>	
<p>39. Name of Witness: <u>[Name]</u></p>		<p>40. Name of Witness: <u>[Name]</u></p>	
<p>41. Name of Witness: <u>[Name]</u></p>		<p>42. Name of Witness: <u>[Name]</u></p>	
<p>43. Name of Witness: <u>[Name]</u></p>		<p>44. Name of Witness: <u>[Name]</u></p>	
<p>45. Name of Witness: <u>[Name]</u></p>		<p>46. Name of Witness: <u>[Name]</u></p>	
<p>47. Name of Witness: <u>[Name]</u></p>		<p>48. Name of Witness: <u>[Name]</u></p>	
<p>49. Name of Witness: <u>[Name]</u></p>		<p>50. Name of Witness: <u>[Name]</u></p>	
<p>51. Name of Witness: <u>[Name]</u></p>		<p>52. Name of Witness: <u>[Name]</u></p>	
<p>53. Name of Witness: <u>[Name]</u></p>		<p>54. Name of Witness: <u>[Name]</u></p>	
<p>55. Name of Witness: <u>[Name]</u></p>		<p>56. Name of Witness: <u>[Name]</u></p>	
<p>57. Name of Witness: <u>[Name]</u></p>		<p>58. Name of Witness: <u>[Name]</u></p>	
<p>59. Name of Witness: <u>[Name]</u></p>		<p>60. Name of Witness: <u>[Name]</u></p>	
<p>61. Name of Witness: <u>[Name]</u></p>		<p>62. Name of Witness: <u>[Name]</u></p>	
<p>63. Name of Witness: <u>[Name]</u></p>		<p>64. Name of Witness: <u>[Name]</u></p>	
<p>65. Name of Witness: <u>[Name]</u></p>		<p>66. Name of Witness: <u>[Name]</u></p>	
<p>67. Name of Witness: <u>[Name]</u></p>		<p>68. Name of Witness: <u>[Name]</u></p>	
<p>69. Name of Witness: <u>[Name]</u></p>		<p>70. Name of Witness: <u>[Name]</u></p>	
<p>71. Name of Witness: <u>[Name]</u></p>		<p>72. Name of Witness: <u>[Name]</u></p>	
<p>73. Name of Witness: <u>[Name]</u></p>		<p>74. Name of Witness: <u>[Name]</u></p>	
<p>75. Name of Witness: <u>[Name]</u></p>		<p>76. Name of Witness: <u>[Name]</u></p>	
<p>77. Name of Witness: <u>[Name]</u></p>		<p>78. Name of Witness: <u>[Name]</u></p>	
<p>79. Name of Witness: <u>[Name]</u></p>		<p>80. Name of Witness: <u>[Name]</u></p>	
<p>81. Name of Witness: <u>[Name]</u></p>		<p>82. Name of Witness: <u>[Name]</u></p>	
<p>83. Name of Witness: <u>[Name]</u></p>		<p>84. Name of Witness: <u>[Name]</u></p>	
<p>85. Name of Witness: <u>[Name]</u></p>		<p>86. Name of Witness: <u>[Name]</u></p>	
<p>87. Name of Witness: <u>[Name]</u></p>		<p>88. Name of Witness: <u>[Name]</u></p>	
<p>89. Name of Witness: <u>[Name]</u></p>		<p>90. Name of Witness: <u>[Name]</u></p>	
<p>91. Name of Witness: <u>[Name]</u></p>		<p>92. Name of Witness: <u>[Name]</u></p>	
<p>93. Name of Witness: <u>[Name]</u></p>		<p>94. Name of Witness: <u>[Name]</u></p>	
<p>95. Name of Witness: <u>[Name]</u></p>		<p>96. Name of Witness: <u>[Name]</u></p>	
<p>97. Name of Witness: <u>[Name]</u></p>		<p>98. Name of Witness: <u>[Name]</u></p>	
<p>99. Name of Witness: <u>[Name]</u></p>		<p>100. Name of Witness: <u>[Name]</u></p>	

1

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
ALBANY, NEW YORK

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6298

CERTIFICATE OF DEATH

Reg. Dist. No.

06316

1. PLACE OF DEATH a. COUNTY <u>Annapolis</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>44 Lafayette Ave.</u>		d. STREET ADDRESS <u>44 Lafayette Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Edythe</u> First <u>Hartt</u> Middle <u>Hartt</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1910</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>49</u> Days <u>49</u> Hours <u>49</u> Min. <u>49</u>	IF UNDER 24 HRS. Months <u>49</u> Days <u>49</u> Hours <u>49</u> Min. <u>49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Maudie V. Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Joseph Hartt</u>	
17. INFORMANT <u>44 Lafayette Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 mon</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 9</u> , 19 <u>58</u> , to <u>June 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>59</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		<u>37 Baker Street</u>	
PHYSICIAN'S NAME (Type) <u>Dr THEODORE H. JOHNSON</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 6-22-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Parson Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keese</u> ADDRESS <u>108 Wash. St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

CERTIFICATE OF DEATH

1908

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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6353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>New York</u> b. COUNTY <u>Bronx</u> 55	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	c. LENGTH OF STAY IN 1b <u>9 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie New York N-9</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>600 CRAIN HIGHWAY</u>		d. STREET ADDRESS <u>537 E-146th ST BX-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Olga</u> Middle <u>Marie</u> Last <u>Gilbert</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Samuel</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clements B. Lehnert</u>	
14. MOTHER'S MAIDEN NAME <u>Marie Linnehan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>257-204448</u>		17. INFORMANT <u>Edward D. Gilbert</u> Address <u>537 E-146th St Bronx 55 N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Metastases</u> DUE TO (c) <u>Carcinoma Cecum</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mch</u> <u>6 wks</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic Failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>—</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u> <u>—</u> <u>—</u>
21. I certify that I attended the deceased from <u>5/25, 1959</u> , to <u>5/31, 1959</u> , that I last saw the deceased alive on <u>6/1, 1959</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>715 Cotter Rd Glen Burnie, Md.</u> DATE SIGNED <u>6/1/59</u>			
ACTUAL SIGNATURE <u>R.W. Prichard</u>		PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louder Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore City - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		45		JAN 15 1890		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 20 1935		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		FARMER	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE		RESPIRATION	
10:00		10		00		P.M.		98.6		70		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHIEF CLERK	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
DATE		PLACE		CITY		COUNTRY		CAUSE		MANNER		OCCUPATION	
JAN 20 1935		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL		FARMER	

1000

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1935

6354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		20X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS ?		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josephine Middle Last Green				4. DATE OF DEATH Month 6 Day 30 Year 1959			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1934		9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Janie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 580X IMMEDIATE CAUSE (a) Acute Atrophy of the Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/20 , 19 59 , to 6/30 , 19 59 , that I last saw the deceased alive on 6/30 , 19 59 , and that death occurred at 2:15 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. M.D. Crownsville State Hospital, Md. 6/30/59 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Md. 6/30/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/59		22c. NAME OF CEMETERY OR CREMATORY Trappe Cemetery		22d. LOCATION (City, town, or county) (State) Talbot County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Verbal M. Seabright				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR JUL 6 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 21 1906

STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF HEALTH
ALBANY, N. Y.
JAN 21 1906

REPORT OF THE COMMISSIONER OF HEALTH
FOR THE YEAR 1905

ALBANY, N. Y.: 1906

PRINTED BY THE STATE PRINTING OFFICE

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/58

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
6355										
CERTIFICATE OF DEATH										
Reg. Dist. No. 06319										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					d. STREET ADDRESS 903 Cherry Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Frederick Middle M. Last Gross					4. DATE OF DEATH Month 6 Day 25 Year 1959					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901		9. AGE (In years last birthday) yrs. 58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chaueffer			10b. KIND OF BUSINESS OR INDUSTRY Paper Box Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John S. Gross					14. MOTHER'S MAIDEN NAME Minnie Ward					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO. 215 09 0602		INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atrophic Cirrhosis of liver with Alcoholism 581.1 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour ----- p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/17 , 19 59 , to 6/25 , 19 59 , that I lost saw the deceased alive on 6/25 , 19 59 , and that death occurred at 9:13 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 6/26/59 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 6/26/59										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/30/59		22c. NAME OF CEMETERY OR CREMATORY Brooklyn Md			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes					ADDRESS 638 N. 9th St		24a. REC'D BY REGISTRAR DATE JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
STATE OF NEW YORK
CERTIFICATE OF DEATH

1935

NEW YORK

1

6356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Hgts.				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5414 Wasena Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle Esterka Last Hajovsky				4. DATE OF DEATH Month June Day 11 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1874	
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Helen Kyval		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Prolonged Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 125. ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 56 to June 8 , 19 59 that I last saw the deceased alive on 6:50 PM , and that death occurred at 6:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1101 Patapsco Ave. DATE SIGNED June 13, 1959							
ACTUAL SIGNATURE Henry G. Summers M.D.				1101 Patapsco Ave.			
PHYSICIAN'S NAME (Type) Henry G. Summers M. D.				Baltimore 25, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		22d. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Gancy				ADDRESS 4001 Ritchie Hwy.		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		SEX Male		DATE OF BIRTH Jan 1, 1900		PLACE OF BIRTH New York City	
MARITAL STATUS Married		OCCUPATION Teacher		PLACE OF DEATH New York City		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Jan 15, 1950		TIME OF DEATH 10:00 AM		PLACE OF DEATH New York City		CAUSE OF DEATH Heart Disease	
NAME OF DECEASED John Doe		SEX Male		DATE OF BIRTH Jan 1, 1900		PLACE OF BIRTH New York City	
MARITAL STATUS Married		OCCUPATION Teacher		PLACE OF DEATH New York City		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Jan 15, 1950		TIME OF DEATH 10:00 AM		PLACE OF DEATH New York City		CAUSE OF DEATH Heart Disease	

1

MAKING STATE CERTIFICATE OF DEATH - BATHING 10

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06321

6299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY MD ? A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eva First Stuart Middle Hamberger Last				4. DATE OF DEATH 6 Month 6 Day 19 Year 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1882	9. AGE (In years lost birthday) yrs. 76	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Ret.		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Savannah, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Withers				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mrs. Winnifred D. Chaney, Gambrills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 11, 1957 to 6/6, 1959 , that I last saw the deceased alive on 6/6/59 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 CATHEDRAL ST G/6/59 DATE SIGNED ACTUAL SIGNATURE Richard N. Peeler M.D. ANNAPOLIS, Md. PHYSICIAN'S NAME (Type) RICHARD N. PEELER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS				24a. REC'D BY REGISTRAR Riverdale, Maryland,		24b. REGISTRAR'S SIGNATURE DATE JUN 9 '59 Arthur S. Kraus	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1933

County of ...

State of ...

Dec. 17, 1933

General ...

Witness

Home

Home

Home

CERTIFICATE OF DEATH

06322

Reg. Dist. No.

6300

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>71 Clay St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Hebron</u> Last <u>Hebron</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Hebron</u>		14. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-5101</u>	
17. INFORMANT <u>Elizabeth Mulkins</u>		Address <u>71 Clay</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Myocardial Infarction, due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Vascular Disease</u> DUE TO (c) <u>1 year</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1959</u> , to <u>June 16, 1959</u> , that I last saw the deceased alive on <u>June 16, 1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Richardson</u>		M.D. <u>110-CLAY ST ANNAPOLIS, MD. 6/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Richardson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Johnson</u>		ADDRESS <u>Annapolis</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6301

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adams County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>181 Clay Street</u>		d. STREET ADDRESS <u>1181 Clay Street</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Henderson</u> Middle Last		4. DATE OF DEATH <u>June</u> Month <u>17</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy, Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Rose Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>01-11-1111</u>	
17. INFORMANT <u>Bessie Henderson</u>		Address <u>181 Clay St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis of the coronary arteries</u> DUE TO (c) <u>Cardiomegaly and atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1, 1959</u> to <u>June 17, 1959</u> that I last saw the deceased alive on <u>June 17, 1959</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>June 17, 1959</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>110-Clay St. Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>108 North St. Annapolis Md</u>	
24b. REC'D BY REGISTRAR <u>[Signature]</u>		24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JUN 23 '59</u>			

TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10332

CERTIFICATE OF GRADUATION

1033

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some words like "I hereby certify" and "this day" are faintly visible.]



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6302

CERTIFICATE OF DEATH

06324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tempe Middle C. Last HENLEY		4. DATE OF DEATH Month June Day 24 Year 19 59.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE -16-1885
9. AGE (In years lost birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Julian A. Clyton		14. MOTHER'S MAIDEN NAME Mary Jane Vaughn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 463X		16. SOCIAL SECURITY NO. INFORMANT Mary L. Henley (2)	
18. CAUSE OF DEATH [Enter only one cause (a), (b), or (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli, secondary to thrombophlebitis, left leg 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain tumor (astrocytoma) right temporal-parietal lobe.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 20, 19 59 to June 24, 19 59 that I last saw the deceased alive on June 24, 19 59 , and that death occurred at 4:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Richardson		ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED 6/25/59	
PHYSICIAN'S NAME (Type) R. L. Richardson		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF June 27-59	22c. NAME OF CEMETERY OR CREMATORY Youngsville Cent	22d. LOCATION (City, town, or county) (State) Youngsville N. C.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR DATE JUN 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>May</u> First <u>Herath</u> Middle <u>lost</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 13, 1887</u> 71 yrs.
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bluffton, S.C.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eustice B. Pinckney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Martha Porcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Robert B. Herath</u>		Address <u>Edgewater, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary failure</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinomatous of intestinal (364)</u> (c) <u>Colon and Lumbosacral Spine</u> <u>Bronchogenic Carcinoma of left lung 8 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1959</u> to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 28, 1959</u> , and that death occurred at <u>3:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED <u>6/28/59</u>			
ACTUAL SIGNATURE <u>Sylvia M. Lini</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>June 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. [unclear]</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>	
ADDRESS <u>2847 Wilson Blvd., Arlington, Va</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

LIBRARY OF CONGRESS

10000



James H. Thompson

James H. Thompson

James H. Thompson

James H. Thompson

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James H. Thompson

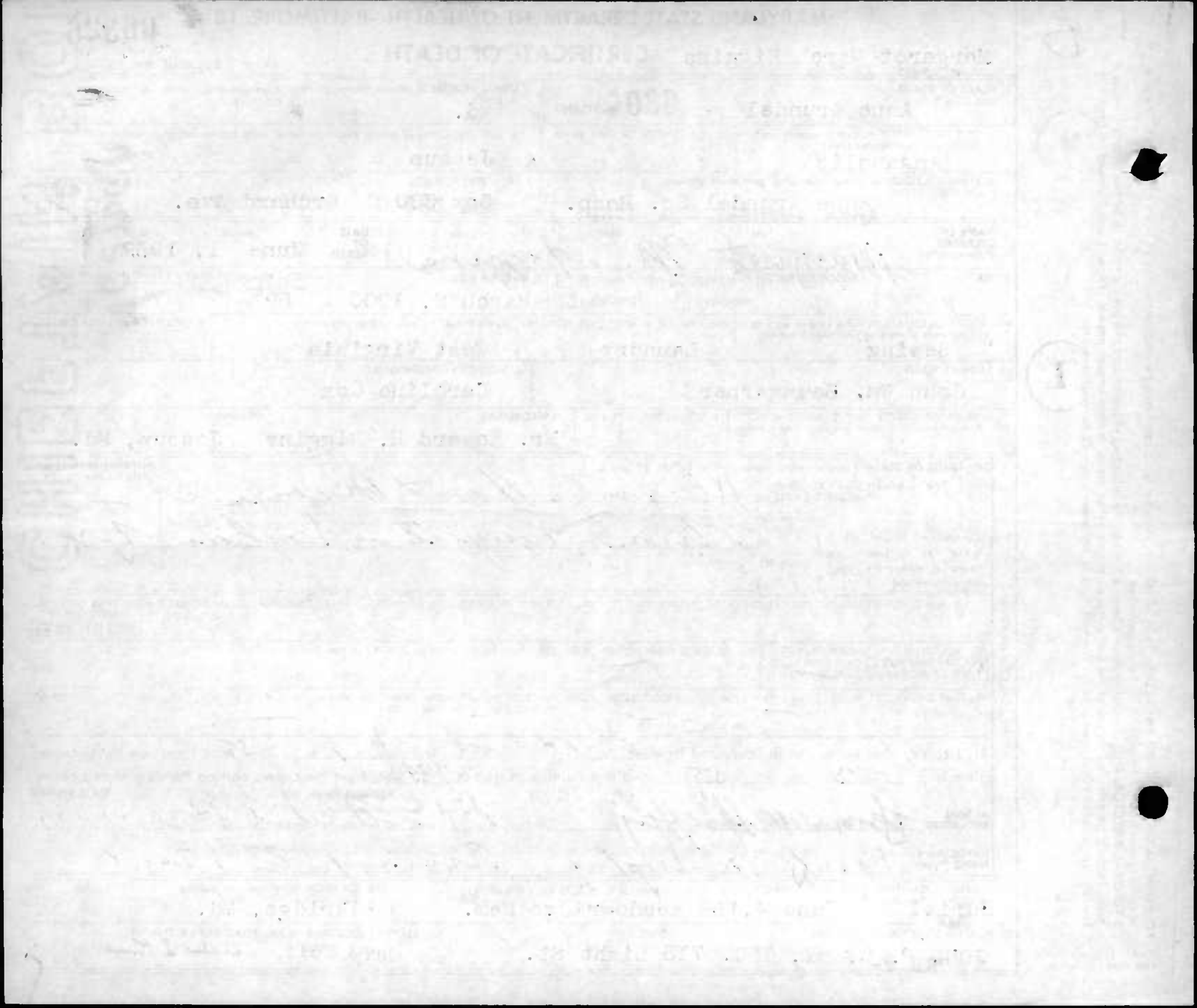
Margaret March Higgins CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel 6304 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b X Jessup	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Co. Hosp.		d. STREET ADDRESS Box 380 C Orchard Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret M. Higgins		4. DATE OF DEATH Month June Day 1 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1900
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wm. Baumgarner		14. MOTHER'S MAIDEN NAME Caroline Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. Howard R. Higgins		Address Jessup, Md.	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease 416 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Chronic Congestive Failure DUE TO (c) ym.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-15-59 to 6-1-59 that I last saw the deceased alive on 5-31-59 , and that death occurred at 7:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Shipley		ADDRESS (Street, city or town, state) 121 Cathedral St. Annapolis, Md.	
PHYSICIAN'S NAME (Type) Frank M. Shipley		DATE SIGNED 6-1-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 4, '59	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.		ADDRESS 715 Light St.	
24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b Since 5/1/59 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 703 Baylor Rd. Glen Burnie Park		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE MD. Same b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same GLEN BURNIE d. STREET ADDRESS Same 703 BAYLOR RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George William Hiltz First Middle Last		4. DATE OF DEATH June 28th 1959 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/25
9. AGE (in years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Salesman		10b. KIND OF BUSINESS OR INDUSTRY New Port, R.I.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert G. Hiltz		14. MOTHER'S MAIDEN NAME Enid Fowler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Naval Reserve.		16. SOCIAL SECURITY NO. 216-32-4937	
17. INFORMANT Mrs. Nancy Hiltz (wife) Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute CARBON Monoxide Poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Seated in car - motor running - closed garage		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year 6/28 1959 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> garage	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Glen Burnie Pk. - A.A. Mo.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-1-59	
22c. NAME OF CEMETERY OR CREMATORY LONDON PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Miller 2101 Frederick Ave.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE James S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Acute Cyanosis
 Poisoning

Seated in car - motor running - closed garage
 Glen Davis Jr. A.A. No. 1
 X

4/2/52

X

X

1

4/2/52

X garage

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 6244 7-14-59 et

6358

CERTIFICATE OF DEATH

Reg. Dist. No.

06328

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u>				c. LENGTH OF STAY IN 1b <u>1 MO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>HOLLAND</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/8/59</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>JAMES Edward Holland.</u>			
14. MOTHER'S MAIDEN NAME <u>Shirley Mae Thompson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Shirley M. Thompson, Churchton Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO <u>Infectious infantile diarrhea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>48 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 19, 1959</u> , to <u>June 20, 1959</u> , that I last saw the deceased alive on <u>June 19, 1959</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Shadyside</u> DATE SIGNED <u>6/23/59</u>			
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Browns</u>		22d. LOCATION (City, town, or county) (State) <u>Churchton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hurdocky</u> ADDRESS <u>Galesville Md</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

9VVVVVVXVV

CERTIFICATE OF DEATH

18 BALTIMORE HEALTH DEPARTMENT STATE OF MARYLAND

100-2528

Page No. 100

100-2528

NAME OF DECEASED

MARRIED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

PLACE OF REINTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6305

CERTIFICATE OF DEATH

06329

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>127 Spa View Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Reuben H. Houghton</u>				4. DATE OF DEATH Month Day Year <u>6-6-1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 31 1897</u>	
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Louis Stedmen</u>				14. MOTHER'S MAIDEN NAME <u>Amiee Nicewaner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>World War I</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Felice Cecil Houghton</u> (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> 19 <u>53</u> , to <u>June 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>59</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Amos Garrett Blvd.</u> <u>6/8/59</u> ACTUAL SIGNATURE <u>S. Borssuck</u> M.D. <u>Amos Garrett Blvd.</u> PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u> <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-10-59</u>		<u>Baltimore National</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John M. Taylor Sons</u> <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1003

1. NAME OF DECEASED JOHN GARNETT SIMS		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH BALTIMORE, MARYLAND		5. DATE OF BIRTH JAN 15 1880		6. PLACE OF DEATH BALTIMORE, MARYLAND	
7. OCCUPATION Carpenter		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. DATE OF DEATH JAN 25 1925		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF PHYSICIAN J. H. [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF DECEASED [Signature]	

1. This certificate is to be filled out by the physician or other person who has attended the deceased during his last illness, or by the coroner if the death was sudden and unexpected, or by the registrar if the death was due to natural causes and the cause of death is known.

2. The cause of death should be stated in plain language, and if possible, the immediate cause should be stated first, followed by the remote cause, and finally the underlying cause.

3. The manner of death should be stated as natural, accidental, or suicidal.

4. The date and time of death should be stated as accurately as possible.

5. The signature of the physician or other person who has attended the deceased during his last illness, or of the coroner, or of the registrar, as the case may be, should be written in ink.

6. This certificate is to be filed in the office of the registrar of deaths, and a copy of it is to be sent to the family of the deceased.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06330

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	c. LENGTH OF STAY IN 1b Over 40 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Same	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) James S. Howard		4. DATE OF DEATH June 14th. 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Calvert County, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James S. William E. Howard		14. MOTHER'S MAIDEN NAME Rachel Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Francis Howard (daughter in law)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self inflicted wound through the mouth with a 38 caliber Colt Rvolver. 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See # 18 (Suicide)	
20c. TIME OF INJURY Month, Day, Year 5.35 p.m. 6/14/59 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Odenton A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/16/59	22c. NAME OF CEMETERY OR CREMATORY Waugh Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Odenton Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley		24a. REC'D BY REGISTRAR JUN 18 '59	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

6306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>H.A. GENERAL Hospital</u>				d. STREET ADDRESS <u>1710 SEVERN AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>J.</u> Middle <u>HUGHES</u> Last		4. DATE OF DEATH <u>6</u> Month <u>13</u> Day <u>1959</u> Year					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1903</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.E.E.S</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES B. HUGHES</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE WINCHESTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HELEN HUGHES</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>azotemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15, 1959</u> to <u>June 13, 1959</u> , that I last saw the deceased alive on <u>6-13-59</u> , and that death occurred at <u>1:40</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>6/15/59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. L. ...</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10-381

Reg. No. 100

STATE OF MARYLAND

HUSBAND

2. NAME OF DECEASED

DECEASED

10. PLACE OF DEATH

11. TIME OF DEATH

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF PHYSICIAN

18. DATE OF DEATH

19. TIME OF DEATH

20. PLACE OF DEATH

21. CAUSE OF DEATH

22. MANNER OF DEATH

23. SIGNATURE OF DECEASED

24. SIGNATURE OF WITNESSES

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF PHYSICIAN

27. DATE OF DEATH

28. TIME OF DEATH

29. PLACE OF DEATH

30. CAUSE OF DEATH

1 ~~X~~
FOR STATE
HEALTH DEPT.

6360

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Same A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
c. LENGTH OF STAY IN 1b 30 years		d. STREET ADDRESS Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 West Norfield Rd. High Point		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Oscar Oscar Hunt) L. Oscar Hunt		4. DATE OF DEATH June 6th. 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last 12 months) Janitor in schools.		10b. KIND OF BUSINESS OR INDUSTRY Bank	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hunt		14. MOTHER'S MAIDEN NAME Katherine - (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 717-07-6246	
17. INFORMANT His driver's License.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/6/59	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/9/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto. Cem.
23. FUNERAL DIRECTOR'S SIGNATURE H. M. J. Vickers		24a. REC'D BY REGISTRAR 17	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE JUN 9 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Dorsey		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey			c. LENGTH OF STAY IN 1b Few Instants.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore-Washington Expressway			d. STREET ADDRESS 1555 Lawrence St. 2226 - Clements		
3. NAME OF DECEASED (Type or print) LEE W. HURST			4. DATE OF DEATH 6/6/59		
5. SEX M			6. COLOR OR RACE Colored		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5-21-1921		
9. AGE (In years last birthday) 38 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Worker			10b. KIND OF BUSINESS OR INDUSTRY Vickers Corp. Inc.		
11. BIRTHPLACE (State or foreign country) Forest City, Ark.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William L. Hurst			14. MOTHER'S MAIDEN NAME America E. Floyd		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No			16. SOCIAL SECURITY NO. Crdenial Card found on his clothes.		
17. INFORMANT Crdenial Card found on his clothes.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Automobile accident, his car collided with another car.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 6/6/59 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Balt. Washington Expressway, Dorsey A.A. Md.			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 6/6/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-59		22c. NAME OF CEMETERY OR CREMATORY Detroit Memorial	
22d. LOCATION (City, town, or county) (State) Detroit, Michigan		23. FUNERAL DIRECTOR'S SIGNATURE Thompson Funeral Home- 7643 Dexter Blvd.-Detroit, Michigan			
24a. REC'D BY REGISTRAR JUN 10 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
1938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. OCCUPATION Carpenter		5. MARITAL STATUS Married		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH Jan 15, 1938		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER Dr. J. H. Smith	
13. SIGNATURE OF NEXT OF KIN Mrs. J. Doe		14. ADDRESS 123 Main St. Baltimore, Md.		15. TELEPHONE 1234	
16. SIGNATURE OF WITNESS John Doe		17. ADDRESS 123 Main St. Baltimore, Md.		18. TELEPHONE 1234	
19. SIGNATURE OF WITNESS John Doe		20. ADDRESS 123 Main St. Baltimore, Md.		21. TELEPHONE 1234	
22. SIGNATURE OF WITNESS John Doe		23. ADDRESS 123 Main St. Baltimore, Md.		24. TELEPHONE 1234	
25. SIGNATURE OF WITNESS John Doe		26. ADDRESS 123 Main St. Baltimore, Md.		27. TELEPHONE 1234	
28. SIGNATURE OF WITNESS John Doe		29. ADDRESS 123 Main St. Baltimore, Md.		30. TELEPHONE 1234	
31. SIGNATURE OF WITNESS John Doe		32. ADDRESS 123 Main St. Baltimore, Md.		33. TELEPHONE 1234	
34. SIGNATURE OF WITNESS John Doe		35. ADDRESS 123 Main St. Baltimore, Md.		36. TELEPHONE 1234	
37. SIGNATURE OF WITNESS John Doe		38. ADDRESS 123 Main St. Baltimore, Md.		39. TELEPHONE 1234	
40. SIGNATURE OF WITNESS John Doe		41. ADDRESS 123 Main St. Baltimore, Md.		42. TELEPHONE 1234	
43. SIGNATURE OF WITNESS John Doe		44. ADDRESS 123 Main St. Baltimore, Md.		45. TELEPHONE 1234	
46. SIGNATURE OF WITNESS John Doe		47. ADDRESS 123 Main St. Baltimore, Md.		48. TELEPHONE 1234	
49. SIGNATURE OF WITNESS John Doe		50. ADDRESS 123 Main St. Baltimore, Md.		51. TELEPHONE 1234	
52. SIGNATURE OF WITNESS John Doe		53. ADDRESS 123 Main St. Baltimore, Md.		54. TELEPHONE 1234	
55. SIGNATURE OF WITNESS John Doe		56. ADDRESS 123 Main St. Baltimore, Md.		57. TELEPHONE 1234	
58. SIGNATURE OF WITNESS John Doe		59. ADDRESS 123 Main St. Baltimore, Md.		60. TELEPHONE 1234	
61. SIGNATURE OF WITNESS John Doe		62. ADDRESS 123 Main St. Baltimore, Md.		63. TELEPHONE 1234	
64. SIGNATURE OF WITNESS John Doe		65. ADDRESS 123 Main St. Baltimore, Md.		66. TELEPHONE 1234	
67. SIGNATURE OF WITNESS John Doe		68. ADDRESS 123 Main St. Baltimore, Md.		69. TELEPHONE 1234	
70. SIGNATURE OF WITNESS John Doe		71. ADDRESS 123 Main St. Baltimore, Md.		72. TELEPHONE 1234	
73. SIGNATURE OF WITNESS John Doe		74. ADDRESS 123 Main St. Baltimore, Md.		75. TELEPHONE 1234	
76. SIGNATURE OF WITNESS John Doe		77. ADDRESS 123 Main St. Baltimore, Md.		78. TELEPHONE 1234	
79. SIGNATURE OF WITNESS John Doe		80. ADDRESS 123 Main St. Baltimore, Md.		81. TELEPHONE 1234	
82. SIGNATURE OF WITNESS John Doe		83. ADDRESS 123 Main St. Baltimore, Md.		84. TELEPHONE 1234	
85. SIGNATURE OF WITNESS John Doe		86. ADDRESS 123 Main St. Baltimore, Md.		87. TELEPHONE 1234	
88. SIGNATURE OF WITNESS John Doe		89. ADDRESS 123 Main St. Baltimore, Md.		90. TELEPHONE 1234	
91. SIGNATURE OF WITNESS John Doe		92. ADDRESS 123 Main St. Baltimore, Md.		93. TELEPHONE 1234	
94. SIGNATURE OF WITNESS John Doe		95. ADDRESS 123 Main St. Baltimore, Md.		96. TELEPHONE 1234	
97. SIGNATURE OF WITNESS John Doe		98. ADDRESS 123 Main St. Baltimore, Md.		99. TELEPHONE 1234	
100. SIGNATURE OF WITNESS John Doe		101. ADDRESS 123 Main St. Baltimore, Md.		102. TELEPHONE 1234	

Page 4 of 4
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
6362					CERTIFICATE OF DEATH					06334									
Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					c. LENGTH OF STAY IN 1b 6 years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Point Pleasant					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Georges Ilgunas					4. DATE OF DEATH Month June Day 15th Year 19 59														
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/67		9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Lithuania									
12. CITIZEN OF WHAT COUNTRY? Lithuania																			
13. FATHER'S NAME Georges Ilgunas					14. MOTHER'S MAIDEN NAME Francis Stakaite														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None					INFORMANT Mr. W.S. Krausman, Point Pleasant, Glen Burnie, Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH ?									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from Aug. 19 57 , to June 15th. 19 59 that I last saw the deceased alive on June 14th. 19 59 , and that death occurred at Noon M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 6/15/59 ACTUAL SIGNATURE Gustave H. Faubert, M.D. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF June 16, 1959					22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park									
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.																			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley					ADDRESS Glen Burnie, Md.					24a. REC'D BY REGISTRAR DATE JUN 18 '59									
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus																			

Information: 100%

1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100 1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200 1201 1202 1203 1204 1205 1206 1207 1208 1209 1210 1211 1212 1213 1214 1215 1216 1217 1218 1219 1220 1221 1222 1223 1224 1225 1226 1227 1228 1229 1230 1231 1232 1233 1234 1235 1236 1237 1238 1239 1240 1241 1242 1243 1244 1245 1246 1247 1248 1249 1250 1251 1252 1253 1254 1255 1256 1257 1258 1259 1260 1261 1262 1263 1264 1265 1266 1267 1268 1269 1270 1271 1272 1273 1274 1275 1276 1277 1278 1279 1280 1281 1282 1283 1284 1285 1286 1287 1288 1289 1290 1291 1292 1293 1294 1295 1296 1297 1298 1299 1300 1301 1302 1303 1304 1305 1306 1307 1308 1309 1310 1311 1312 1313 1314 1315 1316 1317 1318 1319 1320 1321 1322 1323 1324 1325 1326 1327 1328 1329 1330 1331 1332 1333 1334 1335 1336 1337 1338 1339 1340 1341 1342 1343 1344 1345 1346 1347 1348 1349 1350 1351 1352 1353 1354 1355 1356 1357 1358 1359 1360 1361 1362 1363 1364 1365 1366 1367 1368 1369 1370 1371 1372 1373 1374 1375 1376 1377 1378 1379 1380 1381 1382 1383 1384 1385 1386 1387 1388 1389 1390 1391 1392 1393 1394 1395 1396 1397 1398 1399 1400 1401 1402 1403 1404 1405 1406 1407 1408 1409 1410 1411 1412 1413 1414 1415 1416 1417 1418 1419 1420 1421 1422 1423 1424 1425 1426 1427 1428 1429 1430 1431 1432 1433 1434 1435 1436 1437 1438 1439 1440 1441 1442 1443 1444 1445 1446 1447 1448 1449 1450 1451 1452 1453 1454 1455 1456 1457 1458 1459 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 1470 1471 1472 1473 1474 1475 1476 1477 1478 1479 1480 1481 1482 1483 1484 1485 1486 1487 1488 1489 1490 1491 1492 1493 1494 1495 1496 1497 1498 1499 1500 1501 1502 1503 1504 1505 1506 1507 1508 1509 1510 1511 1512 1513 1514 1515 1516 1517 1518 1519 1520 1521 1522 1523 1524 1525 1526 1527 1528 1529 1530 1531 1532 1533 1534 1535 1536 1537 1538 1539 1540 1541 1542 1543 1544 1545 1546 1547 1548 1549 1550 1551 1552 1553 1554 1555 1556 1557 1558 1559 1560 1561 1562 1563 1564 1565 1566 1567 1568 1569 1570 1571 1572 1573 1574 1575 1576 1577 1578 1579 1580 1581 1582 1583 1584 1585 1586 1587 1588 1589 1590 1591 1592 1593 1594 1595 1596 1597 1598 1599 1600 1601 1602 1603 1604 1605 1606 1607 1608 1609 1610 1611 1612 1613 1614 1615 1616 1617 1618 1619 1620 1621 1622 1623 1624 1625 1626 1627 1628 1629 1630 1631 1632 1633 1634 1635 1636 1637 1638 1639 1640 1641 1642 1643 1644 1645 1646 1647 1648 1649 1650 1651 1652 1653 1654 1655 1656 1657 1658 1659 1660 1661 1662 1663 1664 1665 1666 1667 1668 1669 1670 1671 1672 1673 1674 1675 1676 1677 1678 1679 1680 1681 1682 1683 1684 1685 1686 1687 1688 1689 1690 1691 1692 1693 1694 1695 1696 1697 1698 1699 1700 1701 1702 1703 1704 1705 1706 1707 1708 1709 1710 1711 1712 1713 1714 1715 1716 1717 1718 1719 1720 1721 1722 1723 1724 1725 1726 1727 1728 1729 1730 1731 1732 1733 1734 1735 1736 1737 1738 1739 1740 1741 1742 1743 1744 1745 1746 1747 1748 1749 1750 1751 1752 1753 1754 1755 1756 1757 1758 1759 1760 1761 1762 1763 1764 1765 1766 1767 1768 1769 1770 1771 1772 1773 1774 1775 1776 1777 1778 1779 1780 1781 1782 1783 1784 1785 1786 1787 1788 1789 1790 1791 1792 1793 1794 1795 1796 1797 1798 1799 1800 1801 1802 1803 1804 1805 1806 1807 1808 1809 1810 1811 1812 1813 1814 1815 1816 1817 1818 1819

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• 1998 •

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06335

6307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>47 Northwest St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE-SODONIA JAMES</u>		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1878</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry U.S. Naval Acad.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANNAPOLIS-Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>ANNAPOLIS-Md.</u>	
13. FATHER'S NAME <u>HENRY BIAS</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lodgekitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Irving James - 47 Northwest St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 443X DUE TO <u>Hypertensive Cardiac Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yr.</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1</u> , 19 <u>59</u> , to <u>6/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/8</u> , 19 <u>59</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson, M.D.</u>		ADDRESS (Street, city or town, state) <u>37 Behar Street</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '59</u> DATE	
ADDRESS <u>ANNAPOLIS - Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

0083

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

1. Name of deceased: *John A. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15, 1925*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *J. H. Jones*
8. Signature of registrar: *W. B. Brown*
9. Date of registration: *Jan 16, 1925*
10. Place of registration: *State Office*

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6363

CERTIFICATE OF DEATH

06336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AIA Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.H. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>6 W 11th Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA JEFFRIES (JEFFRIES)</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> Day <u>-20</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1864</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Family</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>senescence</u> 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>June</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-20</u> , 19 <u>59</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. <u>Eugene Schnitzer, M.D.</u> ADDRESS (Street, city or town, state) <u>3904 S. Harover St. Baltimore 25, Md.</u> DATE SIGNED <u>6-22-59</u>							
ACTUAL SIGNATURE		M.D. <u>Eugene Schnitzer</u>					
PHYSICIAN'S NAME (Type)		<u>Eugene Schnitzer</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>6-23-59</u>		<u>Glen Haven</u>		<u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Cully Funeral Homes Balt Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6364
CERTIFICATE OF DEATH

06337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 25</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>104 13th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>G.</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Appel</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Sweet</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Florence Bayline</u>		Address <u>319 E. Hamburg St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dangerous Decubitus Ulcer of Back</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-30</u> , 1959, to <u>6-4</u> , 1959, that I last saw the deceased alive on <u>6-4</u> , 1959, and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul A. Mullan MD</u>		ADDRESS (Street, city or town, state) <u>4506 Glenwood Rd Balt Md</u> DATE SIGNED <u>6-6-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 8, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Highway Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>KRAUSE FUNERAL HOME</u>		ADDRESS <u>1216 S. Charles St</u>	
24a. REC'D BY REGISTRAR <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 6365
 CERTIFICATE OF DEATH

06338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Maryland				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 1mo. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1511 McCullough Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Allen Middle James Last Jennings				4. DATE OF DEATH Month 6 Day 22 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/06		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeff Jennings				14. MOTHER'S MAIDEN NAME Dora Bishop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-14-5637		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of the Esophagus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15 , 19 58 , to 6/22 , 19 59 , that I last saw the deceased alive on 6/22 , 19 59 , and that death occurred at 4:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>L. Benedict</i>		ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6/22					
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital, Md. 6/22/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/59		22c. NAME OF CEMETERY OR CREMATORY McClaburn		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Rice</i>		ADDRESS 661 W. Bane St.		24a. REC'D BY REGISTRAR DATE JUN 25 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

REPUBLIC OF CHINA

6265

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06339		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.		
Item 18 Film 244 7-15-59												
6308												
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SEVERNA PARK</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. D. Gen Hospital</u>					d. STREET ADDRESS <u>ROUTE 2 - BOX 342</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Robert J. Jett</u>					4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1959</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 1, 1955</u>		9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>LEE JETT</u>					14. MOTHER'S MAIDEN NAME <u>ANNIE ZULAU</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS ANNIE JETT</u> Address <u>ROUTE 2 - BOX 342 SEVERNA PARK</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> <u>795.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>No underlying condition</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>			Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Wm. Upchurch</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)					DATE SIGNED <u>6-28-59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>6/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM</u>			22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME 1210 BELAIR</u>							ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		April 14, 1928		Memphis, Tennessee	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION		10. RELIGION		11. SOCIAL SECURITY NUMBER		12. DATE OF DEATH	
Attorney		Single		High School		Methodist		68-1234567		April 4, 1968	
13. PLACE OF DEATH											
Memphis, Tennessee											
14. CAUSE OF DEATH											
1. Myocardial infarction											
2. Atherosclerosis of coronary arteries											
3. Hypertension											
4. Diabetes mellitus											
5. Chronic obstructive pulmonary disease											
6. Acute myocardial infarction											
7. Sudden death											
8. Unknown											
9. Other											
10. Suicide											
11. Homicide											
12. Natural causes											
13. Accidental											
14. Poisoning											
15. Other											
16. Date of death											
April 4, 1968											
17. Time of death											
10:15 AM											
18. Signature of Medical Examiner											
J. Edgar Hoover											
19. Signature of Coroner											
J. Edgar Hoover											
20. Signature of Registrar											
J. Edgar Hoover											

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF VITALS, MISSISSIPPI DEPARTMENT OF HEALTH, BUREAU OF VITALS, MEMPHIS, TENNESSEE.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6309

CERTIFICATE OF DEATH

06340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived). If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>25 Larkin</u>	
3. NAME OF DECEASED (Type or print) <u>Eleanor Johnson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Brown</u>		14. MOTHER'S MAIDEN NAME <u>Marriett Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Bertha Green</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary edema, Hypertension</u> DUE TO (c) <u>and Pituitary edema due to nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>245 FM</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6/14/59</u> , 19 _____, to <u>6/14/59</u> , 19 _____, that I last saw the deceased alive on <u>6/14/59</u> , 19 _____, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE <u>R. L. Richardson</u>		M.D. <u>110-CLAY ST. ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>6/15/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Jones</u>	

1. The first part of the paper is devoted to a general discussion of the problem of the origin of life. It is shown that the problem is one of the most important and interesting in the history of science.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06341

1. PLACE OF DEATH a. COUNTY <u>A/A</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A/A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>5 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>522 - 3rd St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET - ELIZABETH JOHNSON</u>				4. DATE OF DEATH <u>6 30 19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-19 76</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>PHILLIP J. JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE CARROLL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>012-36-5264</u>			
17. INFORMANT <u>SARAH JOHNSON</u>				Address <u>522-3rd St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hypertensive Vascular Disease of TV</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Senescent Atherosclerosis</u>							
(c) <u>Orthrin</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>58</u> , to <u>6/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson M.D.</u>				ADDRESS (Street, city or town, state) <u>31 Cabot Street</u>			
PHYSICIAN'S NAME (Type) <u>DR. THEODORE H. JOHNSON</u>				DATE SIGNED <u>9/2/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BREWER HILL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS III</u>				ADDRESS <u>ANNAPOLIS MD</u>		24a. REC'D BY REGISTRAR <u>JUL 9 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1934

CENTRAL AT-CH DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6366

CERTIFICATE OF DEATH

06342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. LENGTH OF STAY IN 1b <u>X PASADENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PFD 3, Box 378</u>				d. STREET ADDRESS <u>RED 3, Box 378</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTHEW REDMAN LIVERMAN</u>				4. DATE OF DEATH Month Day Year <u>JUNE 12 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 July 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Portsmouth P.D.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Matthew J. Liverman</u>				14. MOTHER'S MAIDEN NAME <u>Molly Vaughn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-32-214XA</u>		17. INFORMANT Address <u>MRS MARY STRICKLAND SAM⁺ AS²</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMMORHAGE</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>6 MONTHS</u> <u>6 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on <u>20⁴⁵ AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6-12-59</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Arthur Lanford Jr.</u> M.D. <u>Mountain Rd.</u>							
PHYSICIAN'S NAME (Type) <u>ARTHUR LANFORD JR.</u> <u>Pasadena, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Olive Branch</u>		22d. LOCATION (City, town, or county) (State) <u>Portsmouth, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KIRKLEY, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1940

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. CAUSE OF DEATH [Illegible]</p>	
<p>9. PLACE OF DEATH [Illegible]</p>		<p>10. DATE OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESS [Illegible]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>14. SIGNATURE OF CLERK [Illegible]</p>	

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6367

Item 9 Film G244 6-30-59 et

CERTIFICATE OF DEATH

06343

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8230 Fort Smallwood Rd.</u>			d. STREET ADDRESS <u>8230 Fort Smallwood Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Adolph</u> Middle <u>D</u> Last <u>Long</u>			4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1881</u>	9. AGE (In years last birthday) <u>77 1/2</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. & Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Nelson Long</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Hilda Chaney</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Paul Long Son 8230 Fort Smallwood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>49</u> , to <u>June 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>59</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. Brady Smith</u>			M.D. <u>8471 Ft. Smallwood Road</u>		
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>			<u>PASADENA, MD.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cumberland Md.</u>	
22d. LOCATION (City, town, or county) <u>Cumberland</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. S. Krause</u> ADDRESS <u>Krause Funeral Home 1216 S. Charles St.</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

6368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoney Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoney Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7917 Green Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE MICHAEL LYCETT		4. DATE OF DEATH Month Day Year June 7, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 1, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Michael Lycett		14. MOTHER'S MAIDEN NAME Ann Rebecca O'Neil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-9974	
17. INFORMANT Mrs. Grace Lycett, 7917 Green Drive, Stoney Beach		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Myocardial Failure			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/1 19 58 , to 6/7/59 19 59 , that I last saw the deceased alive on 6/7 19 59 , and that death occurred at 8.15 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Vincent M. Messina M.D. 1403 S. Charles St.		ADDRESS (Street, city or town, state) DATE SIGNED 6/8/59	
PHYSICIAN'S NAME (Type) Vincent M. Messina, M. D. 1403 S. Charles St.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 10, 1959	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	22d. LOCATION (City, town, or county) (State) Ritchie Highway, A. A. County
23. FUNERAL DIRECTOR'S SIGNATURE Flynn & Fleming, Inc., Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE JUN 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 1yr. 1day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 27 N. Carey Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fred			4. DATE OF DEATH Month 6 Day 19 Year 1959				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/79	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steveford		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME George Major			14. MOTHER'S MAIDEN NAME Elizabeth				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-5638		INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/18 , 19 58 , to 6/19 , 19 59 , that I last saw the deceased alive on 6/19 , 19 59 , and that death occurred at 8:15A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 6/19/59					
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital, Md. 6/19/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated 6-24-59		22b. DATE THEREOF 6-24-59		22c. NAME OF CEMETERY OR CREMATORY Greenwood			
22d. LOCATION (City, town, or county) (State) Baltimore, Md.		24a. REC'D BY REGISTRAR JUN 25 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank			
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #2		ADDRESS					

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Page 4

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

113312

DATE OF BIRTH

2362

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6311 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u>	
f. STREET ADDRESS <u>113 CLAY ST.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRIETTA-McGOWAN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8-1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry U.S. Naval Acad.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES SIMMS</u>		14. MOTHER'S MAIDEN NAME <u>Florence Molder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Lewis McGOWAN - 113 CLAY ST. Md.</u>		Address <u>ANNAPOLIS-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>arteriosclerotic Vascular disease</u> DUE TO (c) <u>24th</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24th</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7, 1959</u> to <u>June 8, 1959</u> , that I last saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>R.L. Richardson</u>		DATE SIGNED <u>6/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>		ADDRESS <u>ANNAPOLIS - Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6312

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Convalescent Home				d. STREET ADDRESS 116 Bestgate Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia O. McKay				4. DATE OF DEATH Month June Day 30 , Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH Nov. 19, 1884	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendents		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Warren Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank H. McKay				14. MOTHER'S MAIDEN NAME Catherine Butcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no,		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. Daniel McKay Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1958 to June 30, 1959 , that I last saw the deceased alive on June 30, 1959 , and that death occurred at 11:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6514 W. 57. ANNAPOLIS, MD. DATE SIGNED 7-1-59							
ACTUAL SIGNATURE James H. Martin		M.D. JAMES R. MARTIN					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hearn			

WESTERN STATE ARMYMENT - BIRMINGHAM 12
6312
CERTIFICATE OF DEATH

NAME: [illegible]

AGE: [illegible]

RESIDENCE: [illegible]

DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

SEX: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF MARRIAGE: [illegible]

NAME OF SPOUSE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

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DATE OF DEATH: [illegible]

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PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6313 CERTIFICATE OF DEATH

06348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AA General Hospital				d. STREET ADDRESS Box 316		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Leslie Last Merkle, Sr.				4. DATE OF DEATH Month June Day 9 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1900	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George I. Merkle				14. MOTHER'S MAIDEN NAME Lela May Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary Merkle, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none				INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 1, 1949 , to June 9, 1959 , that I last saw the deceased alive on June 9, 1959 , and that death occurred at 4:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. M. McLaughlin				ADDRESS (Street, city or town, state) RFD 8 Box 442 Pasadena, Md.			
DATE SIGNED June 9, 1959							
PHYSICIAN'S NAME (Type) R. M. McLaughlin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Kirkley				ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE 6/10/59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CHILDS V. A. 1973

6370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenhaven		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenhaven	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cyrial & Orchard Avenues		d. STREET ADDRESS Cyrial & Orchard Avenues	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Claude Middle L. Last Miles, Sr		4. DATE OF DEATH Month JUNE Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1892
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (State or foreign country) Montgomery Co., Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Miles		14. MOTHER'S MAIDEN NAME Ella Flynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-07-4243	
17. INFORMANT Mrs. Esther Buckheit, 6100 Cardiff Ave, ZONE 24		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO Hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1952 to June 25, 1959 , that I last saw the deceased alive on June 25, 1959 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED June 25, 1959			
ACTUAL SIGNATURE R.M. McLaughlin		M.D. Pasadena, Md.	
PHYSICIAN'S NAME (Type) R.M. McLaughlin			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-29-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) 5825 Ritchie Highway, Zone 25
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR JUN 29 1959	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

6371

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forest Glen</i> 15x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>No Street Address</i>		d. STREET ADDRESS <i>Elm House, Hale Pl. & Holman Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gladys</i> First <i>R.</i> Middle <i>Miles</i> Last		4. DATE OF DEATH Month <i>6</i> / Day <i>29</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5, 1909</i>
9. AGE (In years last birthday) <i>49</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>24</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- - - - -</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Sherwood B. Royston</i>		14. MOTHER'S MAIDEN NAME <i>Anna A. Grey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - - - -</i>	
17. INFORMANT <i>Mrs. Sherwood B. Royston</i> Address <i>mother</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>immediate</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>6/29/1959</i> Hour <i>6:45</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>WILLARD F. SMITH, MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6/29/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-2-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Forest Glen, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>DUL 2 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

6372

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN 1b ? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In the woods behind his home.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Bussenaus Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nicolas Miller First Middle Last		4. DATE OF DEATH June 20th. Month Day Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/84
9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) Hungary, Europe.		12. CITIZEN OF WHAT COUNTRY? Naturalized USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes First world War.		16. SOCIAL SECURITY NO. 213-12-4531	
17. INFORMANT Credentials found in his home. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation, by hanging himself to a limb of 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) a tree with a 3/8 inch diameter rope. DUE TO (c) Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) By hanging himself to a limb of a tree with a rope.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 6/20/59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In the woods		20f. (City or town) (County) (State) Pasadena A.A. Maryland.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/20/59 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Ritchie Hwy. A.A. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Gorce ADDRESS 4001 Ritchie Hwy.		24a. REC'D BY REGISTRAR JUN 25 '59 24b. REGISTRAR'S SIGNATURE	

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED COUNT		2. SEX MALE	
3. AGE 20		4. RACE WHITE	
5. OCCUPATION Student		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH 10/10/1918		8. TIME OF DEATH 10:30 AM	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Pneumonia	
11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. H. Smith	
13. SIGNATURE OF DECEASED J. H. Smith		14. SIGNATURE OF WITNESS J. H. Smith	
15. SIGNATURE OF NEAREST RELATIVE J. H. Smith		16. SIGNATURE OF CLERK J. H. Smith	
17. SIGNATURE OF JURY J. H. Smith		18. SIGNATURE OF JURY J. H. Smith	
19. SIGNATURE OF JURY J. H. Smith		20. SIGNATURE OF JURY J. H. Smith	
21. SIGNATURE OF JURY J. H. Smith		22. SIGNATURE OF JURY J. H. Smith	
23. SIGNATURE OF JURY J. H. Smith		24. SIGNATURE OF JURY J. H. Smith	
25. SIGNATURE OF JURY J. H. Smith		26. SIGNATURE OF JURY J. H. Smith	
27. SIGNATURE OF JURY J. H. Smith		28. SIGNATURE OF JURY J. H. Smith	
29. SIGNATURE OF JURY J. H. Smith		30. SIGNATURE OF JURY J. H. Smith	
31. SIGNATURE OF JURY J. H. Smith		32. SIGNATURE OF JURY J. H. Smith	
33. SIGNATURE OF JURY J. H. Smith		34. SIGNATURE OF JURY J. H. Smith	
35. SIGNATURE OF JURY J. H. Smith		36. SIGNATURE OF JURY J. H. Smith	
37. SIGNATURE OF JURY J. H. Smith		38. SIGNATURE OF JURY J. H. Smith	
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41. SIGNATURE OF JURY J. H. Smith		42. SIGNATURE OF JURY J. H. Smith	
43. SIGNATURE OF JURY J. H. Smith		44. SIGNATURE OF JURY J. H. Smith	
45. SIGNATURE OF JURY J. H. Smith		46. SIGNATURE OF JURY J. H. Smith	
47. SIGNATURE OF JURY J. H. Smith		48. SIGNATURE OF JURY J. H. Smith	
49. SIGNATURE OF JURY J. H. Smith		50. SIGNATURE OF JURY J. H. Smith	
51. SIGNATURE OF JURY J. H. Smith		52. SIGNATURE OF JURY J. H. Smith	
53. SIGNATURE OF JURY J. H. Smith		54. SIGNATURE OF JURY J. H. Smith	
55. SIGNATURE OF JURY J. H. Smith		56. SIGNATURE OF JURY J. H. Smith	
57. SIGNATURE OF JURY J. H. Smith		58. SIGNATURE OF JURY J. H. Smith	
59. SIGNATURE OF JURY J. H. Smith		60. SIGNATURE OF JURY J. H. Smith	
61. SIGNATURE OF JURY J. H. Smith		62. SIGNATURE OF JURY J. H. Smith	
63. SIGNATURE OF JURY J. H. Smith		64. SIGNATURE OF JURY J. H. Smith	
65. SIGNATURE OF JURY J. H. Smith		66. SIGNATURE OF JURY J. H. Smith	
67. SIGNATURE OF JURY J. H. Smith		68. SIGNATURE OF JURY J. H. Smith	
69. SIGNATURE OF JURY J. H. Smith		70. SIGNATURE OF JURY J. H. Smith	
71. SIGNATURE OF JURY J. H. Smith		72. SIGNATURE OF JURY J. H. Smith	
73. SIGNATURE OF JURY J. H. Smith		74. SIGNATURE OF JURY J. H. Smith	
75. SIGNATURE OF JURY J. H. Smith		76. SIGNATURE OF JURY J. H. Smith	
77. SIGNATURE OF JURY J. H. Smith		78. SIGNATURE OF JURY J. H. Smith	
79. SIGNATURE OF JURY J. H. Smith		80. SIGNATURE OF JURY J. H. Smith	
81. SIGNATURE OF JURY J. H. Smith		82. SIGNATURE OF JURY J. H. Smith	
83. SIGNATURE OF JURY J. H. Smith		84. SIGNATURE OF JURY J. H. Smith	
85. SIGNATURE OF JURY J. H. Smith		86. SIGNATURE OF JURY J. H. Smith	
87. SIGNATURE OF JURY J. H. Smith		88. SIGNATURE OF JURY J. H. Smith	
89. SIGNATURE OF JURY J. H. Smith		90. SIGNATURE OF JURY J. H. Smith	
91. SIGNATURE OF JURY J. H. Smith		92. SIGNATURE OF JURY J. H. Smith	
93. SIGNATURE OF JURY J. H. Smith		94. SIGNATURE OF JURY J. H. Smith	
95. SIGNATURE OF JURY J. H. Smith		96. SIGNATURE OF JURY J. H. Smith	
97. SIGNATURE OF JURY J. H. Smith		98. SIGNATURE OF JURY J. H. Smith	
99. SIGNATURE OF JURY J. H. Smith		100. SIGNATURE OF JURY J. H. Smith	

7375

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Anne Stroudel

Sex: Female

Age: 7 months

Place of Birth: Virginia

Place of Death: Maryland House of Correction

Occupation: Thomas

Marital Status: M.

Religion: Baptist

Date of Birth: June 30, 1930

Name: Kate

Birth: 11-2-1932

Death: 11-2-1932

I.V. Foster (1)

Infant's Name: Infante Miller

Infant's Name: North Martin

Maryland House of Correction Records

Attest: I hereby certify that the foregoing is a true and correct copy of the original record as it appears in the files of the Maryland House of Correction.

Signature of Medical Examiner: [Signature]

Date: [Date]

Place: [Place]

Signature of Registrar: [Signature]

Date: [Date]

Place: [Place]

Signature of Medical Examiner: [Signature]

Date: [Date]

Place: [Place]

Signature of Registrar: [Signature]

Date: [Date]

Place: [Place]

Signature of Medical Examiner: [Signature]

Date: [Date]

Place: [Place]

THIS CERTIFICATE IS TO BE FILED IN THE RECORDS OF THE MARYLAND STATE DEPARTMENT OF HEALTH AND IN THE RECORDS OF THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06353

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN lb Few hours ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Brooklyn 25 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) New Cut Road			d. STREET ADDRESS 3816 Tenth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Marrow Moore Jr.			4. DATE OF DEATH June 23rd. 19 59		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/21 2/23/31	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Selector for A & P Warehouse			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John M. Moore			14. MOTHER'S MAIDEN NAME Florence Cavano		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es. no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-28-7271	17. INFORMANT Address Mrs. Audrey Moore, Severn, Md. (wife)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self inflicted wound to the head through the 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mouth with a Remington Rifle 22 caliber. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See# 18			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6/23/59 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wife's home	20f. (City or town) Severn	(County) A.A. Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/26/59	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	22d. LOCATION (City, town, or county) Glen Burnie, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. Cully Funeral Homes 130 E. Fort Ave.			24a. REC'D BY REGISTRAR DATE JUN 24 '59		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bristol	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George MAURICE MORELAND		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1872
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	
11. BIRTHPLACE (State or foreign country) Anne Arundel County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard F. Moreland		14. MOTHER'S MAIDEN NAME Mary M. Stallings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Mabel Ida O'Neill		Address Bristol, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 , 19____, to 17 June , 19 59 , that I last saw the deceased alive on 13 June , 19 59 , and that death occurred at 2:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R B Sasscer		ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 17 June 59	
PHYSICIAN'S NAME (Type) R B Sasscer MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 20, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery	22d. LOCATION (City, town, or county) (State) Lothian, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6375

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 9, 11, 12 Film G244 7-7-59 et

6314

CERTIFICATE OF DEATH

Reg. Dist. No.

06355

1. PLACE OF DEATH a. COUNTY <u>AA County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Pindell</u> Middle <u>Joseph</u> Last <u>S</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1901</u>
9. AGE (In years day birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>29</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Pindell</u>		14. MOTHER'S MAIDEN NAME <u>Francis Pindell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Carrie Pindell</u>	
17. INFORMANT <u>Carrie Pindell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiac disease</u> DUE TO (c) <u>Dissecting</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8:00</u> PM, 19 <u>59</u> , to <u>29</u> PM, 19 <u>59</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>11:00</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. Richardson</u>		ADDRESS (Street, city or town, state) <u>110 - CHAY ST ANNAPOLIS MD.</u>	
DATE SIGNED <u>M.D.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

100-100000-1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

00350

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH MEMPHIS, TENNESSEE	
7. CAUSE OF DEATH MURDER		8. MANNER OF DEATH HOMICIDE		9. PLACE OF BIRTH MOBILE, ALABAMA	
10. OCCUPATION Attorney		11. EDUCATION High School		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS OTHER None		20. PREVIOUS OTHER None		21. PREVIOUS OTHER None	
22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

6315

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,				c. LENGTH OF STAY IN 1b X Edgewater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Glebe Hgts		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEARL Middle PITKEVITS Last				4. DATE OF DEATH Month JUNE Day 12 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Kacmarek				14. MOTHER'S MAIDEN NAME Maggie (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-22-6510A			
17. INFORMANT Mr. Carl Pitkevits- Husband- Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hours 4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April , 19 57 , to June , 19 59 that I last saw the deceased alive on May , 19 59 , and that death occurred at 3:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Francis I Codd				M.D.			
PHYSICIAN'S NAME (Type) Francis I Codd MD				Gov. Ritchie Highway, Severna Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR JUN 16 '59	
				24b. REGISTRAR'S SIGNATURE Cirrus L. Hume			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR
may be retained
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the carbon copies. Pages 1 and 2 should be filed with

VS A15 (4)
15M 10/57

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4

6376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>4 mo. 12 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>424 Chesapeake Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anita</u>		First Middle Last <u>Pollard</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Brown</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Hypostatic</u> <u>422.2</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Fibrosis and Degeneration</u> DUE TO (c) <u>- - -</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>- - -</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>- - -</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>- - -</u> p. m. <u>- - -</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>- - -</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I attended the deceased from <u>1/31, 19 59</u> , to <u>6/12, 19 59</u> , that I last saw the deceased alive on <u>6/12, 19 59</u> , and that death occurred at <u>8:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hosp., Md.</u>				DATE SIGNED <u>6/13/59</u>	
PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		<u>Crownsville State Hosp., Md.</u>				<u>6/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5376

DATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910-01-15		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Report		Time of Report	
1950-01-20		10:00 AM		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]		1950-01-25		10:00 AM	
Name of Informant		Relationship		Address		City		State		Zip		Signature of Informant		Date of Report		Time of Report		Signature of Registrar		Date of Report	
Jane Doe		Wife		123 Main St		New York City		New York		10001		[Signature]		1950-01-25		10:00 AM		[Signature]		1950-01-25	

6377

CERTIFICATE OF DEATH

Reg. Dist. No.

3. PLACE OF DEATH a. COUNTY <u>Anne-Grunde</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>8 month 7 days</u>		d. STREET ADDRESS <u>307 N. Central Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNIE (Anna)</u> First <u>May</u> Middle <u>Rice</u> Last		4. DATE OF DEATH <u>6</u> Month <u>27</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Laura</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Crownsville State Hospital</u> Address <u>Statistical Data Sheet</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Arterio sclerotic Heart Disease.</u> DUE TO (c) <u>Arteriosclerosis Cardiovascular Disease.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1958</u> , to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 27, 1959</u> , and that death occurred at <u>12:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Enrique J. del Campo</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>6-27-59</u>	
PHYSICIAN'S NAME (Type) <u>Enrique J. del Campo</u>		<u>Crownsville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM. BALTO.</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph Collick</u> ADDRESS <u>1417 E. Prig...</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6337

Page 1 of 1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10/15/18		New York, N.Y.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
10/25/18		10:30 AM		Home		Dr. Smith		St. Mary's	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
St. Mary's		10/26/18		10:00 AM		St. Mary's		10/26/18	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Physician		Hospital	
10/25/18		10:30 AM		Home		Dr. Smith		St. Mary's	

6316

CERTIFICATE OF DEATH

06359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William F. Reiley</u>				4. DATE OF DEATH Month <u>6</u> - Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1897</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker Ret</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Reiley</u>				14. MOTHER'S MAIDEN NAME <u>MARY FAYE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. GEORGE REICH</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC CORONARY DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u> <u>10 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JUNE 1955</u> to <u>28 JUNE 1959</u> , that I last saw the deceased alive on <u>28 JUNE 1959</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>4 Soutgate Ave Annapolis Md</u>			
DATE SIGNED <u>6/29/59</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cent</u>		22d. LOCATION (City, town, or county) <u>Bracklyn Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6317

CERTIFICATE OF DEATH

06360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>—</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l Hosp.</u>				d. STREET ADDRESS <u>110 Sixth Ave. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Remillieux</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1894</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & A. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Remillieux</u>				14. MOTHER'S MAIDEN NAME <u>Katherine (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Mr. Robert Stephens</u>		Address <u>Glen Burnie 9 Lincoln Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS & MYOCARDIAL INFARCT</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CORONARY DISEASE</u> DUE TO (c) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-3</u> , 1959, to <u>6-6</u> , 1959, that I last saw the deceased alive on <u>6-6</u> , 1959, and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate AVE</u>		DATE SIGNED <u>6/6/59</u>	
PHYSICIAN'S NAME (Type) <u>ANNAPOLIS MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> ADDRESS <u>Glen Burnie</u>				24a. REC'D BY REGISTRAR <u>JUN 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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UNITED STATES OF AMERICA

1

6318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Severn	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle Last RISLEY		4. DATE OF DEATH Month June Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1892
		9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME (Unknown) Risley		14. MOTHER'S MAIDEN NAME Frances Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-14-2087	
		INFORMANT MRS JULIA RISLEY Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC VASCULAR DIS DUE TO UNKNOWN (c)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/27 , 19 59 , to 6/29 , 19 59 , that I last saw the deceased alive on June 29 , 19 59 , and that death occurred at 2:48 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Beck		ADDRESS (Street, city or town, state) 41 Southgate Ave., DATE SIGNED 6/29/59	
PHYSICIAN'S NAME (Type) Edward S. Beck		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-2-1959	
22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) GLEN BURNIE, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirby		ADDRESS Glen Burnie, Md.	
24c. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OF DEATH

1918

ATEROLECTIC PASCHAS DIS 2-1-18
GENERAL MEMORIAL

6/11 22 6/11 27

Chas. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06362

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville - Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel General</u>		d. STREET ADDRESS <u>Elvaton - Box 254 Obrecht Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William</u> First Middle Last	4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Local #101</u>	11. BIRTHPLACE (State or foreign country) <u>Finland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nestor Ristomaki</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or discharge service) <u>Yes WW#</u>	
16. SOCIAL SECURITY NO. <u>213-09-4312</u>		17. INFORMANT Address <u>Mrs. Hilja Ristomaki Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DATE SIGNED <u>6/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 29, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. V. Singleton Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 6320
 CERTIFICATE OF DEATH

07505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 502 STATE ST. ANNAPOLIS				c. LENGTH OF STAY IN 1b 2 MO.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAURA ELIZABETH RODGERS				4. DATE OF DEATH 6/29 Month Day Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/73	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TOWN PT AA Co Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HEZERIAH WARD				14. MOTHER'S MAIDEN NAME SALLY E RODGERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		INFORMANT Address FELLSWORTH RODGERS, CHURCHTON MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO ARTERIOSCLEROSIS, GENERALIZED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC CHOLECYSTITIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1954 to 29 JUNE 1959 , that I last saw the deceased alive on 28 JUNE 1959 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward J. Beck		M.D. H. Southgate Lane		ADDRESS (Street, city or town, state) Annapolis Md.		DATE SIGNED 6/30/59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/59		22c. NAME OF CEMETERY OR CREMATORY 203RER		22d. LOCATION (City, town, or county) (State) Telesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Buried Hardaway Salisbury Rd				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 10 '59	
				24b. REGISTRAR'S SIGNATURE Caroline & Francis			

BP

CENTRAL CHINA



Handwritten notes and stamps, including dates like 1947 and 1948, and various administrative markings.

Handwritten notes and stamps, including dates like 1947 and 1948, and various administrative markings.

Handwritten notes and stamps, including dates like 1947 and 1948, and various administrative markings.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman Island 20x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CAMPER Middle M. Last SCHARCH				4. DATE Found Month June Day 3 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1935	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Tilghman, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Camper Scharch				14. MOTHER'S MAIDEN NAME Gretchen Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Camper Scharch, Tilghman, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, Found Drowned. 975X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned. Apparently jumped from Bay Bridge.			
20c. TIME OF INJURY Month, Day, Year Found 6/3 1959				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay	
20f. (City or town) Anne Arundel Md.				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/4/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		22d. LOCATION (City, town, or county) Sherwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Harrison, St. Michael				24a. REC'D BY REGISTRAR me		24b. REGISTRAR'S SIGNATURE Arthur S. Kins	

6322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MO.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10215 McKENDREE AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. A. General</u>		d. STREET ADDRESS <u>Annapolis, MO.</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>WERNER</u> Last <u>SCHNOOR</u>		4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1959</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MO.</u>	
11. BIRTHPLACE (State or foreign country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WERNER G. SCHNOOR</u>		14. MOTHER'S MAIDEN NAME <u>JANET RAWLINGS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>U. G. SCHNOOR</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Prematurity with Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>BIRTH</u> DUE TO (c) <u>BIRTH</u>		INTERVAL BETWEEN ONSET AND DEATH <u>BIRTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/26</u> , 19 <u>59</u> , to <u>6/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>59</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip Briscoe</u>		ADDRESS (Street, city or town, state) <u>95 Calverton St</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP BRISCOE</u>		DATE SIGNED <u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 29-59</u>		22b. DATE THEREOF <u>June 29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>Arthur J. Kraus</u>	
ADDRESS <u>Annapolis Md</u>		DATE <u>JUL 1 '59</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063352XV3

00361

CERTIFICATE OF DEATH

1933

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

[Vertical text on the right margin, possibly a filing or archival stamp.]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Margate, P.O. Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 06X-2	
c. LENGTH OF STAY IN 1b few minutes			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marley Creek		d. STREET ADDRESS Route 1 Libery Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gary Michael Schroeder		4. DATE OF DEATH June 26 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/1943
9. AGE (in years last birthday) 15 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Walter Schroeder		14. MOTHER'S MAIDEN NAME Alma Martinez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Walter Schroeder (father)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Went in the water and 50 feet from shore was taken with cramps (and drowned).	
20c. TIME OF INJURY Month, Day, Year 3.30 a.m. 6/26/59 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marley Creek		20f. (City or town) Margate A.A. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) Woodlawn (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd.	
24a. REC'D BY REGISTRAR DATE JUL 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6323 Item 2 Film 2447-1-59 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06366
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle T. Last SHEARER		4. DATE OF DEATH Month June Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 80
11. BIRTHPLACE (State or foreign country) Jamestown, ALA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Toles		14. MOTHER'S MAIDEN NAME Susie Dubarry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. R. Powell-415 Penn St. - Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Jun 1959 to 19 Jun 1959 ; that I last saw the deceased alive on 18 Jun 1959 , and that death occurred at 9:37A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Beck M.D.		ADDRESS (Street, city or town, state) 41 Southgate Ave., DATE SIGNED 6/19/59	
PHYSICIAN'S NAME (Type) Edward S. Beck		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/23/1959	22c. NAME OF CEMETERY OR CREMATORY Chattanooga Memorial	22d. LOCATION (City, town, or county) (State) Chattanooga Tenn.
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE JUN 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that

John T. Jones

of the County of Dallas, State of Texas,

do hereby certify that

John T. Jones

is the owner of the following described land, to-wit:

Section 1, Township 10N, Range 12E, County of Dallas, State of Texas.

And he further certifies that the same is subject to a mortgage in favor of

the State of Texas, for the purpose of securing the payment of the same.

Witness my hand and seal this 1st day of January, 1900.

John T. Jones

Notary Public in and for the State of Texas.

My commission expires the 1st day of January, 1901.

Subscribed and sworn to before me this 1st day of January, 1900.

Notary Public in and for the State of Texas.

My commission expires the 1st day of January, 1901.

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6379

CERTIFICATE OF DEATH

06367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First <u>Crandall</u> Middle <u>Sherbert</u> Last		4. DATE OF DEATH <u>June</u> Month <u>16</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Julius E. Crandell</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>Gertrude Sherbert-- Lothian, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>56</u> , to <u>20 May</u> 19 <u>59</u> , that I last saw the deceased alive on <u>20 May</u> 19 <u>59</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. J. Weems</u>		DATE SIGNED <u>6/16/59</u>	
PHYSICIAN'S NAME (Type) <u>G. J. Weems, M.D.</u>		ADDRESS (Street, city or town, state) <u>Huntingtown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lothian, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-Maryboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>G. J. Weems</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06368

6380

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 615 Elizabeth Rd.			d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Bert W. Shryock			4. DATE OF DEATH June 22rd 19 59		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/77		9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired salesman		10b. KIND OF BUSINESS OR INDUSTRY Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bert Shryock			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 474-09-7858		17. INFORMANT Mrs. Michel J. Majoros (daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Minneapolis, Minn.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert		M.D. Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DATE SIGNED 6/22/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 26/59	22c. NAME OF CEMETERY OR CREMATORY Lakewood Cem.		22d. LOCATION (City, town, or county) Minneapolis, Minn.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard P. Sington		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MI

AL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West River</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> <u>16X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>Route 1 Box 234</u>		
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>LEROY</u> Last <u>SNOUFFER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24- 1918</u>		9. AGE (In years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assit. Fire Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Andrews A.A. Force Base.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Otto Snouffer</u>			14. MOTHER'S MAIDEN NAME <u>Ethel M. Benton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>18 June 45-14 Jan 46.</u>		17. INFORMANT <u>Mildred E. Snouffer</u> Address <u>Same as # 2.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off of boat</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:05 P.M. June 21, 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water</u>	
		20f. (City or town) <u>West River</u>		(County) <u>Anne Arundel</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/24/59</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26 -59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amiras Bros</u>			ADDRESS <u>1661- Good Hope Road S.E. Washington, D.C.</u>		
24a. REC'D BY REGISTRAR <u>JUN 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>			

TO HOSPITAL OR
may be retained.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

the hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 207 Chester Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle SNOWBALL Last SNOWBALL				4. DATE OF DEATH Month June Day 3 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. 54 yrs.	
9. AGE (In years lost birthday)		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?				10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? ?							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?				16. SOCIAL SECURITY NO. ?		17. INFORMANT Address ?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Pulmonary DUE TO Tuberculosis with Cavitation and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO pleural Effusion (c) pleural Effusion							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1959 , to June 3, 1959 , that I last saw the deceased alive on June 3, 1959 , and that death occurred at 11:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED June 3, 1959							
ACTUAL SIGNATURE R. L. Richardson				M.D. 110 Clay St.,			
PHYSICIAN'S NAME (Type) R. L. Richardson				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY University of Md. Anatomy Board		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese Funeral Home, 108 Washington St.				24a. REC'D BY REGISTRAR DATE AUG 13 '59		24b. REGISTRAR'S SIGNATURE Carter & Hume	
Annapolis, Md.							

Annapolis, Md.

CERTIFICATE OF DEATH

6382

PLACE OF DEATH HOME		COUNTY BALTIMORE	
CITY BALTIMORE		STATE MARYLAND	
DECEASED NAME JAMES EARL RAY		SEX MALE	
DATE OF BIRTH MAY 19 1928		AGE 35	
OCCUPATION MINISTER		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH MISSOURI		DATE OF DEATH MAY 25 1963	
TIME OF DEATH 10:00 AM		PLACE OF INTERMENT GREENWICH CEMETERY	
NAME OF FUNERAL HOME GREENWICH FUNERAL HOME		SIGNATURE OF FUNERAL HOME [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]	
SIGNATURE OF JUDGE [Signature]		SIGNATURE OF CLERK [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6383

06370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eirleigh Heights,		c. LENGTH OF STAY IN 1b Few Instants		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Governor Ritchie Highway			d. STREET ADDRESS 2141 Linden Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Joseph L. Speaks			4. DATE OF DEATH June 3rd. 19 59		
5. SEX M	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/37	9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Speaks			14. MOTHER'S MAIDEN NAME Irene Brown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-30-9210		17. INFORMANT Irene Speaks (mother) Address 2141 Linden Ave. Balt.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull. Crushed chest. 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was fixing a car when another car hit it in the rear.			
20c. TIME OF INJURY Month, Day, Year 1.50 o. m. 6/3/59 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ritchie Highway	
20f. (City or town) Earleigh Heights, A.A. Md.		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		M.D. Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DATE SIGNED 6/5/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1959		22c. NAME OF CEMETERY OR CREMATORY St. Anthony's Cem.	
22d. LOCATION (City, town, or county) Baltimore, Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Katie R. Williams</i>		ADDRESS 322 N. ...		24a. REC'D BY REGISTRAR JUN 8 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06371

6384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundle MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1428 Oakdale Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle George Last Sponheimer				4. DATE OF DEATH Month June Day 20 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 27, 1885		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 1 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crossing Watchman			10b. KIND OF BUSINESS OR INDUSTRY N.J. Central		11. BIRTHPLACE (State or foreign country) Berlinsville, Pa.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Rueben Sponheimer				14. MOTHER'S MAIDEN NAME Lydia Kline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 714-05-3172		17. INFORMANT Helen H. Sponheimer Address 1428 Oakdale Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V.D. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 Minutes 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8.13.51 , 19____, to 6.20.59 , 19____, that I last saw the deceased alive on 6.14.59 , 19____, and that death occurred on 3.22.59 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 206 S. Gilmer St DATE SIGNED 6.21.59							
ACTUAL SIGNATURE Nathan Racusin			M.D. Balto. 22 Md				
PHYSICIAN'S NAME (Type) NATHAN RACUSIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 24, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Memorial Park		22d. LOCATION (City, town, or county) (State) Allentown, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Cole ADDRESS 1913 W. Batts St				24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6324

CERTIFICATE OF DEATH

06372

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE MARYLAND		STATE Maryland		COUNTY 00	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis, Md		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Selby on the Bay			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital				STREET ADDRESS (If rural give location) 6th avenue,.			
3. NAME OF DECEASED (First) (Middle) (Last) John James Sweeney (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year) June 1, 19 59-			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov 15, 1893	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Eugene Sweeney				14. MOTHER'S MAIDEN NAME Henrietta Coulter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT & ADDRESS James Sweeney Kentland, Maryland -			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
16.3 X IMMEDIATE CAUSE (A) Cancer lung c							
ANTECEDENT CAUSE(S) DUE TO (B) metastasis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5:31, 1959, to 5:31, 1959, that I last saw the deceased alive on 5:31, 59, and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Frank M. Shaffer</i>				ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i>		DATE SIGNED <i>6-1-59</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/3/59		NAME OF CEMETERY OR LOCATION Arlington National		LOCATION (City, town, or county) Arlington Virginia.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>		25. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
DATE JUN 5 '59							

6325

CERTIFICATE OF DEATH

06373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
1. STREET ADDRESS <u>RFD-3, Box-210</u>							
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>McKnight</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/04</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Edmund C. McKnight</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Baird</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Elaine Wallace</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular ^{Thrombosis} Accident. ^{Arterio}</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive vasculas disease</u> DUE TO (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>7 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>June 9, 1959</u> , that I last saw the deceased alive on <u>June 10, 1959</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.				<u>Mayo Road, Edgewater, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Sylvia Lim</u>				<u>6/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6-13-59</u>		<u>EVERGREEN Cemetery</u>		<u>MURPHY FREESBORO TENN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100413

CERTIFICATE OF DEATH

1958

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

NAME - Mr. J. W. Smith

DATE - 10-15-58

AGE - 65

SEX - Male

RACE - White

RELIGION - Protestant

MARITAL STATUS - Married

EDUCATION - High School

OCCUPATION - Farmer

CAUSE OF DEATH - Heart Disease

PLACE OF DEATH - Home

DATE OF BIRTH - 10-15-1913

PLACE OF BIRTH - Iowa

DATE OF DEATH - 10-15-58

PLACE OF DEATH - Home

DATE OF DEATH - 10-15-58

PLACE OF DEATH - Home

DATE OF DEATH - 10-15-58

PLACE OF DEATH - Home

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u> </u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>519 Greenway S.E.</u>				d. STREET ADDRESS <u>519 Greenway S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH</u> <u>TRUMBULL</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>24</u> , <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u> </u>		
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taverns</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Batczyk</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Audrey Phelps</u>		Address <u>117 Greenway S.E. Glen Burnie, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty infiltration of liver</u> 581.1 INDEX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u> DUE TO (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Hour a. m. p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				DATE SIGNED <u>6/24/59</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>29 June '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>RV Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

6386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b lyr. 8days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie A. Thompson Tubman		4. DATE OF DEATH Month Day Year 6 24 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 2/22/1877 9. AGE (In years last birthday) 83 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Tubman		14. MOTHER'S MAIDEN NAME Mary E. Thompson Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) ----- INTERVAL BETWEEN ONSET AND DEATH Few months Since Adm.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left femur			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from <u>6/16</u> 19 <u>58</u> , to <u>6/24</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/24</u> 19 <u>59</u> , and that death occurred at <u>1:20A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6/24/59			
ACTUAL SIGNATURE <i>L. Benediot</i>		PHYSICIAN'S NAME (Type) L. Benediot, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-59	22c. NAME OF CEMETERY OR CREMATORY Thompson town
22d. LOCATION (City, town, or county) (State) Harlock, Maryland		24a. REC'D BY REGISTRAR Arthur L. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampton		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6326

CERTIFICATE OF DEATH

06376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>71 Conduit Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JULIA H. VanCleve</u>				4. DATE OF DEATH Month Day Year <u>June 14, 1959</u> <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Atlantic, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Katherine Pugh</u>				14. MOTHER'S MAIDEN NAME <u>Peter Morrissey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> <u>no</u>				16. SOCIAL SECURITY NO. <u>Mr. Morris Edward VanCleve</u>			
17. INFORMANT <u>Husband- same as # 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischaemic melioidosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 1957, to <u>June</u> , 1959, that I last saw the deceased alive on <u>June 12</u> , 1959, and that death occurred at <u>12:35</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral</u> DATE SIGNED <u>6/16/59</u>							
ACTUAL SIGNATURE <u>John H. Hedeman</u> M.D. <u>Annapolis, Md.</u>							
PHYSICIAN'S NAME (Type) <u>John H. Hedeman MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>			
24a. REC'D BY REGISTRAR DATE <u>JUN 19 1959</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>WASH. DC</i> b. COUNTY <i>A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural.</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A. ANNIE ARUNDEL GENERAL</i>		d. STREET ADDRESS <i>126 10th St. S.E.</i>	
3. NAME OF DECEASED (Type or print) <i>Paul M. Washington</i>		4. DATE OF DEATH Month <i>6</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>32</i> yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov U.S.A</i>	11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>William Washington</i>	
14. MOTHER'S MAIDEN NAME <i>Hattie Washington</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Agnes Washington</i> Address <i>126-10th St. S.E.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination due to</i> <i>812X</i> DUE TO <i>Fracture Skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident while 50-killed by a car while he was working on his car</i>	
20c. TIME OF INJURY Month, Day, Year <i>2:30</i> Hour a. m. <i>6:14</i> p. m. <i>1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) <i>Highway nr. Annapolis A.A. Co. MD</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-17-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Int. Olive</i>
22d. FUNERAL DIRECTOR'S SIGNATURE <i>Chapman B. Boyd</i>		22e. LOCATION (City, town, or county) (State) <i>Washington DC</i>	
23. REC'D BY REGISTRAR <i>Arthur L. Thomas</i>		24. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06378

6327

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ANNAPOLIS (CAPE ST. CLAIR)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GEN.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY C. WATTS				4. DATE OF DEATH JUNE 6, 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-12	9. AGE (In years lost, birthday) 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service man		10b. KIND OF BUSINESS OR INDUSTRY Oil Burners		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar A. Watts				14. MOTHER'S MAIDEN NAME Katherine Raabe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address Mrs Louise C. Watts- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE-INTERNAL 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CARCINOMA OF COLON DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jesse L. Wilkins M.D.				ADDRESS (Street, city or town, state) 98 Cathedral St. Annapolis, Md.			
PHYSICIAN'S NAME (Type) JESSE L. WILKINS				DATE SIGNED 6/6/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-9-1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bethesda, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley Funeral Home ADDRESS 1300 E. Hopping St. Glen Burnie, Maryland				24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6328

CERTIFICATE OF DEATH

06379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>68 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>48 Madison Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT LUTHER WAYSON</u>		4. DATE OF DEATH <u>JUNE 6, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		13. FATHER'S NAME <u>JOHN WESLEY WAYSON</u>	
14. MOTHER'S MAIDEN NAME <u>HENRIETTA SHEPHERD</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-18-7802</u>		17. INFORMANT <u>W. ALVIN WAYSON</u> Address <u>1401 POPLAR ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GEN.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D.		ADDRESS (Street, city or town, state) <u>98 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>6/6/59</u>	
PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06380

6388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Mill Road 100 ft. east of old Telegraph				/d. STREET ADDRESS Box 174b		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle G. Last Whisman				4. DATE OF DEATH Month June Day 16 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1905		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech.		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Wytheville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marco Whisman				14. MOTHER'S MAIDEN NAME Pelina Waddle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-18-1115		17. INFORMANT Address Mrs Mary Bell Whisman-Wife-same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.S. Fisher M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/16/59	
EXAMINER'S NAME (Type) R.S. FISHER				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 19 Jun. 1959		22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cem. Annapolis, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kinkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

• *Review*

2021.11.27

may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

06381

6329

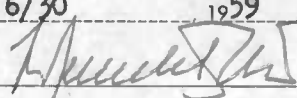
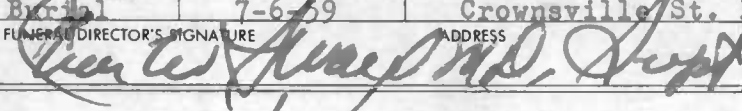
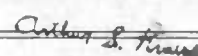
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy L Middle WINCHESTER Last				4. DATE OF DEATH Month June Day 1 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-18	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY ANNAPOLIS BANK & T. Co.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME ALBERT WINCHESTER				14. MOTHER'S MAIDEN NAME AGNES LAMB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT AGNES WINCHESTER				Address #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases to liver 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the bladder DUE TO (c) 1 yr (?) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/12/58 19___, to 6/1/59 19___, that I last saw the deceased alive on 6/1/59 19___, and that death occurred at 11:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md. DATE SIGNED 6/2/59							
ACTUAL SIGNATURE Edwin DAVIS, Jr. M.D.				PHYSICIAN'S NAME (Type) Edwin DAVIS, Jr.			
22a. BURIAL (Specify place)				22b. DATE THEREOF June 4-1959			
22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY				22d. LOCATION (City, town, or county) (State) ANNA POLIS MD.			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR - SONS				24a. REC'D BY REGISTRAR JUN 4 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06382	
6389										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Anne Arundel					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
c. LENGTH OF STAY IN 1b 2 yrs. 2 mo. 27 days					d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louis Abraham Winters					4. DATE OF DEATH Month Day Year 6 30 19 59						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/67		9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming					10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard Winters					14. MOTHER'S MAIDEN NAME Julienne Steward						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/3 , 19 57 , to 6/30 , 19 59 , that I last saw the deceased alive on 6/30 , 19 59 , and that death occurred at 2:00 A. M., from the causes and on the date stated above.										DATE SIGNED 6/30/59	
ACTUAL SIGNATURE 					ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.						
PHYSICIAN'S NAME (Type) L. Benedict, M. D.					Crownsville State Hospital, Md.					6/30/59.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 7-6-59		22c. NAME OF CEMETERY OR CREMATORY Crownsville St. Hosp.		22d. LOCATION (City, town, or county) (State) Crownsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE 					24a. REC'D BY REGISTRAR DATE JUL 8 '59		24b. REGISTRAR'S SIGNATURE 				

19282

1

6390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>X GLEN BURNIE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FURNACE BRANCH ROAD</u>		d. STREET ADDRESS <u>FURNACE BRANCH ROAD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCINDA C. WOOD</u>		4. DATE OF DEATH Month Day Year <u>JUNE 6 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MONT ALTO, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS CARBAUGH</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINA HIPPENSTEIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mrs Edna Madsons, Glen Burnie, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>3 wks</u> <u>Since 1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month Day Year p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/20</u> , 19 <u>56</u> , to <u>6/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Leonard H. Flax, M.D. 113 7th Ave Brooklyn Park, Md.</u> ACTUAL SIGNATURE <u>Leonard H. Flax, M.D. Baltimore 25, Md.</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/9/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BURNS HILL</u>		22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Shore</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
ADDRESS <u>Waynesboro, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

115231

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

6980

REG. NO. 11

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1968</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, MD</i>	
10. OCCUPATION <i>Teacher</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Catholic</i>	
13. MARITAL STATUS <i>Married</i>		14. DATE OF MARRIAGE <i>1950</i>		15. NAME OF SPOUSE <i>Jane Doe</i>	
16. NAME OF PHYSICIAN <i>Dr. Smith</i>		17. NAME OF HOSPITAL <i>St. Mary's</i>		18. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i>	
19. NAME OF FUNERAL HOME <i>ABC Funeral Home</i>		20. NAME OF MINISTER <i>Rev. Jones</i>		21. NAME OF CLERGYMAN <i>Rev. Jones</i>	
22. NAME OF CORONER <i>John Doe</i>		23. NAME OF JURY <i>None</i>		24. NAME OF JUDGE <i>None</i>	
25. NAME OF ATTORNEY <i>None</i>		26. NAME OF NOTARY <i>None</i>		27. NAME OF WITNESS <i>None</i>	
28. NAME OF DECEASED'S FATHER <i>John Doe</i>		29. NAME OF DECEASED'S MOTHER <i>Jane Doe</i>		30. NAME OF DECEASED'S SISTER <i>None</i>	
31. NAME OF DECEASED'S BROTHER <i>None</i>		32. NAME OF DECEASED'S UNCLE <i>None</i>		33. NAME OF DECEASED'S AUNT <i>None</i>	
34. NAME OF DECEASED'S GRANDFATHER <i>None</i>		35. NAME OF DECEASED'S GRANDMOTHER <i>None</i>		36. NAME OF DECEASED'S GRANDSISTER <i>None</i>	
37. NAME OF DECEASED'S GRANDBROTHER <i>None</i>		38. NAME OF DECEASED'S GREAT-GRANDFATHER <i>None</i>		39. NAME OF DECEASED'S GREAT-GRANDMOTHER <i>None</i>	
40. NAME OF DECEASED'S GREAT-GRANDSISTER <i>None</i>		41. NAME OF DECEASED'S GREAT-GRANDBROTHER <i>None</i>		42. NAME OF DECEASED'S GREAT-GREAT-GRANDFATHER <i>None</i>	
43. NAME OF DECEASED'S GREAT-GREAT-GRANDMOTHER <i>None</i>		44. NAME OF DECEASED'S GREAT-GREAT-GRANDSISTER <i>None</i>		45. NAME OF DECEASED'S GREAT-GREAT-GRANDBROTHER <i>None</i>	
46. NAME OF DECEASED'S GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		47. NAME OF DECEASED'S GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		48. NAME OF DECEASED'S GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
49. NAME OF DECEASED'S GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>		50. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		51. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>	
52. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>		53. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>		54. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>	
55. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		56. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>		57. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>	
58. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		59. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		60. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
61. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>		62. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		63. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>	
64. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>		65. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>		66. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>	
67. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		68. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>		69. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>	
70. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		71. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		72. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
73. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>		74. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		75. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>	
76. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>		77. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>		78. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>	
79. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		80. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>		81. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDBROTHER <i>None</i>	
82. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		83. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		84. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
85. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		86. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		87. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
88. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		89. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		90. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
91. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		92. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		93. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
94. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		95. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		96. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
97. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		98. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		99. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	
100. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDFATHER <i>None</i>		101. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDMOTHER <i>None</i>		102. NAME OF DECEASED'S GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GREAT-GRANDSISTER <i>None</i>	

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